Ψ ROCKLAND COUNTY PSYCHOLOGICAL SOCIETY Ψ

Membership Directory Information Form

Please **TYPE** or **PRINT** all information as you would like your listing to read. DEADLINE: **April 1, 2016**

Name_____ Highest Degree_____

Please indicate with a [√] address to which RCPS mail should be sent.
Please indicate with an [X] address(es) to be listed in Membership Directory, including apartment or suite number.
Please indicate with an [+] if address has changed in the past 12 months, or is new to RCPS.

[ ] Home Address_____
_____ Home Telephone ( )_____
[ ] Office Address_____
_____ Office Telephone ( )_____ Fax #:_____
Website: _____ E-mail:_____
[ ] Office Address_____
_____ Office Telephone ( )_____

Psychologist License #_____ State_____
School Psychologist Certification #_____ State_____
Diplomate, ABPP:Clinical ___ Counseling___ Group____ School___ Hypnosis___ Neuropsychology ____

SCHOOL PSYCHOLOGISTS: Please list your School:_____
District/Address_____ Tel #:_____

Major Field (Please note: This section is intended for psychologists & students **in academic & teaching settings**. Limit 3 fields)

Clinical Neuropsych_____
Clinical Psychology_____
Community Psych_____
Counseling Psych_____
Developmental Psych_____
Educational Psych_____
Environmental Psych_____
Experimental Psych_____
Forensic Psych_____
Industrial/Organizational____
Medical Psych_____
Personality Psych_____
Physiological Psych_____
Professional Psych_____
Psychology of Women_____
Psychopharmacology_____
Rehabilitation Psych _____
School Psych_____
Social Psych_____
Other (specify)_____

Professional Setting (check as many as apply):

Independent Practice _____
Industry _____
Developmental Ctr _____
Psychiatric Center _____
Correctional Facility _____
Hospital _____
Clinic _____
School _____
University/College _____
Social Agency _____
Medical _____
Other (specify) _____

If in Independent Practice, please check all that apply below. **You must give license # above**.

Psychotherapy
Children _____
Adolescents_____
Adults _____
Family _____
Couple _____
Group _____

Psychological Testing
Children _____
Adolescents _____
Adults _____

Educational Testing
Children _____
Adolescents_____
Adults _____

Vocational Testing
Children _____
Adolescents_____
Adults _____

State specialty practice (e.g., behavior therapy, biofeedback, psychoanalysis, etc.) **only if you are in independent practice**.
(Maximum three specialties)

_____

Do you accept Medicaid? _____ Other Insurance Accepted: _____

Language Fluencies: _____

Are you a member of APA: _____ NYSPA _____ NYASP_____ Others_____

Presentations Interested in Offering: _____

Return this form to: Charlene von Ohlen, PhD, 572 Route 303 Blauvelt, NY 10913