

WSP MEMBERSHIP APPLICATION FORM

Community membership (\$125) _____

Professional membership (\$350) _____

Gold membership (\$700) _____

Additional contribution _____

Total: _____

Fax this form to 202-237-2730 or mail to:

Membership Coordinator
Washington School of Psychiatry
5028 Wisconsin Ave., NW, Suite 400
Washington, DC 20016-4118

Name: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Work phone: _____ Home phone: _____

Fax: _____ Email: _____

(Make Checks payable to: Washington School of Psychiatry)

Please bill my credit card for the amount indicated above. Master card Visa

Account number _____ Expiration date _____