ICISF TEAM MEMBERSHIP APPLICATION

Please Print Neatly to Avoid Data Entry Errors

Your Team Information must be updated in the ICISF Team database to utilize this application. To update your Team information contact **hotline@icisf.org**

Team Name: _____ ICISF Team Number _____

Team Coordinator: _____ Team Clinical Director: _____

Address: _____ City, State, Zip/Postal Code: _____

Country: _____ Email Address: _____

Daytime Phone: _____ ___ YES, ICISF may email me membership renewal notices & LN Newsletters

Evening Phone: _____ ___ YES, I would like to receive email updates from ICISF.

Number of Current Team Members: _____

Two Year Team Membership Rate - $260.00 for up to 20 members, $10.00 for each member over 20.

A team information form must accompany the membership application.

This membership is optional and voluntary.

By completing this application our team is applying for team membership in ICISF and do hereby attest that the facts contained herein are accurate and that I adhere to the professional standards/ethics of my profession. I further understand that membership in ICISF is in no way an endorsement of competency, nor an endorsement to practice.

Signature: _____

Payment Information

All checks should be payable to ICISF. Checks must be in US funds & drawn from a US bank. Returned checks are subject to a $20.00 check fee. If paying by credit card, please use one of the options listed below.

Method of Payment (Please check one):

__ Check #
__ Master Card
__ American Express
__ Visa
__ Discover

For Credit Card Payment

Name as it appears on card: _____
Card #: _____
Exp. Date: _____/_____ Sec. Code _____
Signature: _____

PLEASE MAIL COMPLETED FORM TO
ICISF. Inc.
3290 Pine Orchard, Suite 106
Ellicott City, MD 21042
Fax To: (410) 750-9601

Please address any questions regarding ICISF membership to:
Michelle Parks at (410) 750-9600 or mparks@icisf.org

ICISF Team Membership Roster

First Name	Last Name	Email Address