

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: **January 2, 2012**

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 _____	Experimental Psych _____	Psychology of Women _____
Clinical Psychology _____	Forensic Psych _____	Psychopharmacology _____
Community Psych _____	Industrial/Organizational _____	Rehabilitation Psych _____
Counseling Psych _____	Medical Psych _____	School Psych _____
Developmental Psych _____	Personality Psych _____	Social Psych _____
Educational Psych _____	Physiological Psych _____	Other (specify) _____
Environmental Psych _____	Professional Psych _____	

Professional Setting (check as many as apply):

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

If in independent practice, please check all that apply below. You must give license # above.

Psychotherapy	Psychological Testing	Educational Testing	Vocational Testing
Children _____	Children _____	Children _____	Children _____
Adolescents _____	Adolescents _____	Adolescents _____	Adolescents _____
Adults _____	Adults _____	Adults _____	Adults _____
Family _____			
Couple _____			
Group _____			

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: _____

Languages fluent in: _____

Are you a member of APA: _____ NYSPA _____ NYASP _____ Others _____

Return this form to: **Tracey Polizzi, PhD. 30 Minerick Drive Stony Point, NY 10980**