

MIP Membership Application 2008-2009

THE INFORMATION BELOW WILL BE INCLUDED IN THE 2009 DIRECTORY

NAME: _____ DEGREE(S): _____

STREET: _____

CITY: _____ STATE: _____ ZIP: _____

If you have a second office, please list the town: _____

Home Phone: (_____) _____

Office Phone: (_____) _____

Fax: (_____) _____

E-mail: _____

AFFILIATION WITH MIP (please check appropriate boxes):

- | | |
|--|--|
| <input type="checkbox"/> ADVISOR | <input type="checkbox"/> MEMBER |
| <input type="checkbox"/> BOARD OF DIRECTOR | <input type="checkbox"/> CANDIDATE |
| <input type="checkbox"/> SUPERVISOR | <input type="checkbox"/> POSTGRADUATE FELLOW |
| <input type="checkbox"/> FACULTY | <input type="checkbox"/> COMMITTEE MEMBER |
| <input type="checkbox"/> GRADUATE | Name of Committee(s): _____ |
-

The 2009 MIP Directory will include a section listing clinical specialties. If you would like to be included in this section of the Directory, please indicate by checking the relevant specialties. **Please no more than 5 clinical specialties.**

Adult Psychotherapy/Psychoanalysis is not listed because it is assumed most MIP members are active in these specialties.

- | | |
|---|---|
| <input type="checkbox"/> Addictions/Substance Abuse | <input type="checkbox"/> Fertility/Infertility |
| <input type="checkbox"/> Adolescents | <input type="checkbox"/> Gay/Lesbian Issues |
| <input type="checkbox"/> Adolescents (late) | <input type="checkbox"/> Medical Illness |
| <input type="checkbox"/> Adoption | <input type="checkbox"/> Men's Issues |
| <input type="checkbox"/> Affective/Mood Disorders | <input type="checkbox"/> Mother-Infant Psychotherapy |
| <input type="checkbox"/> Anxiety Disorders | <input type="checkbox"/> Older Adults |
| <input type="checkbox"/> Bereavement/Grief & Loss | <input type="checkbox"/> Parenting Issues |
| <input type="checkbox"/> Children | <input type="checkbox"/> Personality Disorders |
| <input type="checkbox"/> Chronic Mental Illness/Schizophrenia | <input type="checkbox"/> Psychopharmacology |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Sexual Abuse |
| <input type="checkbox"/> College Students | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Couple's Psychotherapy | <input type="checkbox"/> Sexual Offenders |
| <input type="checkbox"/> Cross Cultural Issues | <input type="checkbox"/> Spiritual Issues |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Supervision/Consultation
Psychotherapy only |
| <input type="checkbox"/> Disability | <input type="checkbox"/> Supervision/Consultation
Psychoanalysis and Psychotherapy |
| <input type="checkbox"/> Divorce/Custody Issues | <input type="checkbox"/> Transgendered/Transsexuality/Sexuality
and Gender Issues |
| <input type="checkbox"/> Dual Diagnosis | <input type="checkbox"/> Trauma/Dissociative Disorder/PTSD |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Family Therapy | <input type="checkbox"/> Women's Issues |

Please see other side > >>>

Foreign Language Speaking Clinician

French

German

Hebrew

Italian

Russian

Spanish

other (specify) _____

Please make your check for \$395. payable to **MIP** and send it with this form to:

MIP

Liz Martin

288 Washington St., #343

Brookline, MA 02445