

EUROPEAN BRANCH OF THE AMERICAN COUNSELING ASSOCIATION (EB-ACA)
MEMBERSHIP APPLICATION



Professional/Regular \$50.00
 Student \$30.00
 CHECK # _____ Pay to: EB-ACA

Please Circle:
 NEW RENEWAL
 Date: _____

Title: Mr. Mrs. Miss Ms. Dr. Other _____

Name: _____

Job Title: _____

Military ID Card Holder? YES NO Gender: FEMALE MALE

CONTACT INFORMATION. *(Attach card if you have one).*
 The following is Public Domain Information and will be published in the EB-ACA Membership Directory.

Work Address: _____ Home Address: _____

DSN Phone: _____ Phone: _____
 Civ Phone: _____ Fax: _____
 Fax: _____ Email: _____

STUDENTS ONLY

I'm claiming student status: _____ Date: _____
 (Signature)

Faculty Member: _____ Initials: _____
 (Print Name)

The following is not Public Domain and will not be published.

Please check appropriate work setting(s):

a. Alcohol and Drug	d. Schools/University	g. Mental Health
b. Family Advocacy	e. Chaplain	h. Private Practice
c. ACS/Family Support	f. Nurse	i. Other _____

Licensed: NO YES If Yes: State: _____ Certified by: _____

ACA Member: NO YES If Yes: Division: _____

Would you like information about becoming a member of the American Counseling Association? **YES NO**

MAIL TO:

Robert Sheely CMR 459 Box 10107 APO AE 09139	or	Robert Sheely Hauptstrasse 53 91077 Hetzles
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Contact Info: Cell phone: 0151-5028-8738 or Commercial 09134-5575 / Fax 09134-907032
 Email: sjpsych@yahoo.com