



**SCAPA MEMBERSHIP APPLICATION
(Please Print)**

NAME _____

Address: _____

Phone: _____ Email _____

Facility _____ Title _____

Facility address: _____

Facility phone: _____ Email _____

Do you prefer your SCAPA mailings go to ___ home ___ work

Are you CMS recognized certified? AC-BC _____ AAP-BC _____ AP-BC _____

ACC _____ ADC _____ APC _____ CTRS _____ COTA _____

(Certification is not required to be a member of SCAPA)

Would you be interested in hosting a district workshop at your facility? _____

Would you be interested in serving on a SCAPA committee? _____

Would you be interested in speaking for a SCAPA workshop? _____

Topics or areas of expertise _____

Sponsored by SCAPA member: (name) _____

How did you hear or Learn About SCAPA? _____

Memberships are for individuals and are non-transferable

SCAPA Tax ID number: 58-2282268

******* Please mail this form and a check for \$40.00 to:**

Linda Wright

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Gaffney, SC 29342

Lswright3304@gmail.com