2023 ATSA Clinical Member Renewal Invoice

Send Payment to:
Association for the Treatment and Prevention of Sexual Abuse
9450 SW Gemini Drive, Suite 24121
Beaverton, Oregon 97008-7105
membership@atsa.com
Phone: (503) 643-1023
Fax: (503) 643-5084

1. Membership Category

☐ ATSA Clinical Member

2. Professional Contact Information

Prefix	Suffix	Degree, License, Credentials to appear after your name

First Name	Middle Name or Initial	Last Name

Professional Agency/Organization

Professional Address

Professional Address (continued)

Professional City	State/Province/Country	Zip/Postal Code

Professional Phone and Extension	Other Phone

Professional Email (Primary)	Other E-mail Address (only used by ATSA staff)

3. Mailing Address for Journal and ATSA Mailings

Mailing Address

Mailing Address (continued)

Mailing City	Mailing State/Province	Zip Code/Postal Code

Mailing Country (If other that USA)

a. If analogous organizations and/or individuals involved in research endeavors request the ATSA mailing list, I consent to have my name included on that list. Yes ☐ No ☐ *ATSA does not sell member information.*

b. I would like to receive the hard copy Journal by mail ☐ *or* only access online ☐

4. ATSAList

Restrictions on Use of the LIST SERVE: I agree not to use the list serve to send or post any message or material that is illegal, harassing, libelous, defamatory, abusive, threatening, harmful, vulgar, obscene, profane, pornographic, offensive, intentionally inaccurate, or otherwise objectionable. I also agree not to use this list serve to communicate information or material that encourages conduct that could constitute a criminal offense, give rise to civil liability, or otherwise violate any applicable local, state, national or international law or regulation. **Under no circumstances will ATSA be liable in any way for any unauthorized or illegal use of the list serve, or any loss or damage of any kind incurred as a result of that unauthorized or illegal use.**

Choose one:

☐ Individual postings (may be 5 to 50 emails per day)
List Serve email address: ___________________________________

☐ Digest Version (compilation of daily discussions,1 or 2 emails per day)
List Serve email address: ___________________________________

☐ I DO NOT wish to participate in electronic discussion group

5. Demographics (optional)

a. **Date of Birth** (dd/mo/yr)**:**

b. **Gender**	☐ Female	☐ Male	☐ Non-binary	☐ Prefer not to say

c. **Race and Ethnicity** (select all that apply)

☐ Aboriginal, Indigenous, or First Nations	☐ Asian	☐ Black or African American
☐ Biracial ______________________________________		
☐ Hispanic, Latin, or Spanish	☐ Middle Eastern or North American	
☐ Pacific Islander or Hawaiian Native	☐ White or European	
☐ If you don't see yourself reflected in these options, please tell us about your race and ethnicity:		

Reasons for collecting information on ethnicity and race:

Race and ethnicity information is now being asked because we believe collecting this demographic data helps identify needed improvements to the diversification of our membership and associated benefits. It is also a way to be able to strengthen our ability to provide services to clients of all ethnic and racial communities. Our selections are based on the 2020 US Census Race/Ethnicity guidelines.

6. ATSA Membership Data

This information will appear in the Members Only section of the ATSA website. If requested, this information will be provided in response to requests for referrals received at the ATSA office.

☐ Yes, add me to the referral list	☐ No, not at this time

Agency:

County:

(County not needed for members in Alaska, Canada or outside of the US)

a. **Identified Discipline** (choose one best answer)

☐ Psychology	☐ Criminal Justice	☐ Social Work
☐ Medicine/Psychiatry	☐ Counseling	☐ Law
☐ Administration	☐ Other:	

ATSA

b. Identified Profession (choose one best answer)		
☐ Therapist/Treatment Provider	☐ Assessor/Evaluator	☐ Researcher/Academician
☐ Probation/Surveillance Officer	☐ Attorney/Judge	☐ Victim Advocate
☐ Sex Offender Program Administrator	☐ Other:	
c. Primary Job Function (choose one best answer)		
☐ Administrative	☐ Clinical Outpatient	☐ Probation/Parole
☐ Clinical Inpatient	☐ Education	☐ Research
☐ Victim Advocate	☐ Other:	

d. How Do You Define Your Services (check all that apply)	
☐ Alcohol/Drug Abuse	☐ Probation/Parole
☐ Civil Commitment Evaluations/Treatment	☐ Program for non-adjudicated Offenders
☐ Community Mental Health	☐ Psychiatric Hospital
☐ Community SO Outpatient	☐ Psychosexual/Forensic Evaluations
☐ Employment or Housing Advocacy/Services	☐ Residential
☐ Faith-based Sex Offender Treatment	☐ Services for non-offending pedophiles
☐ Polygraphy	☐ University/College
☐ Prison/Jail	☐ Victim Advocacy
☐ Other:	
e. Client Population Served (check all that apply)	
☐ Adult Males	☐ Developmentally Disabled Adults
☐ Adult Females	☐ Developmentally Disabled Adolescents
☐ Adolescent Males	☐ Hearing Impaired
☐ Adolescent Females	☐ Abuse Reactive Children
☐ Pre-pubescent Males (12 and under)	☐ Families of Adolescents/Children who Offend
☐ Pre-pubescent Females (12 and under)	☐ Family/Spouse of Adults who Offend

f. Dual Language (check all that apply)				
☐ American Sign	☐ French	☐ Spanish	☐ Vietnamese	☐ Other:

g. Physiological Assessment (check all that apply)		
☐ Viewing Time	☐ PPG	☐ Polygraph

h. Consultation/Training (check all that apply)	
☐ Treatment of Adolescents who Sexually Offend	☐ Program Evaluation
☐ Treatment of Adults who Sexually Offend	☐ Psychosexual Assessments
☐ Children with Sexual Behavior Problems	☐ Registration Notification
☐ Civil Commitment Services	☐ Risk Assessment
☐ Community Management Strategies	
i. Remote Phone/Video Teletherapy Options	
☐ Yes	☐ No

ATSA

7. ATSA Membership Terms

I agree to support the objectives of the Association and to read and abide by the provisions of the ATSA Practice Guidelines and Professional Code of Ethics, which may include having my name published in the Forum newsletter in the event of an ethical sanction against me by the ATSA ethics committee.

I understand that if I am charged with a felony, am accused, investigated, and/or involved in unprofessional or unethical conduct, or am denied membership in or terminated from a professional organization, I must fax or email information pertaining to the allegations and/or investigations to ATSA within two weeks of the event, or I risk my membership being denied or revoked.

I understand that any false, inaccurate, or misleading information, including omissions provided on this form may result in my membership being denied or revoked.

I agree that I will not forward or share ATSA List Serve emails outside of subscribed ATSA membership. Failure to abide by the ATSA List Serve Terms of Usage may result in removal from the List Serve and/or ATSA Membership.

By renewing my membership, I agree to the above noted statements and affirm that all the information I am providing is true, accurate and complete.

✕ Member Signature:	**Date:**

8. Payment (Dues are not pro-rated and are based on the calendar year January - December)

Are you a part of an ATSA Chapter? ☐ Yes ☐ No Remember to renew your chapter membership too!

$ 225.00	**2023 ATSA Clinical Member Dues**
$ 35.00	Suggested Donation (optional) for Public Policy and Prevention Efforts (*May Not Be Tax Deductible)*
$	**Total amount to be charged to credit card (USD)**

Method of Payment: ☐ Check ☐ Money Order ☐ Visa ☐ Amex ☐ MasterCard ☐ Discover

Security Code: (last 3 digits on back of card, or 4 digits on front of card if using AMEX)

____ - ____ - ____ - ____   __ / __

CREDIT CARD NUMBER   **EXPIRATION DATE**

(Exchange rates are set by credit card companies, not by ATSA, so fees may vary slightly based on current exchange rates.)

Name and Billing Address as it appears on card statement

Authorized credit card signature: