



**COUNCIL OF GRADUATE PROGRAMS IN
COMMUNICATION SCIENCES AND DISORDERS**

P.O. Box 26532 ● Minneapolis, MN 55426 ● (952) 920-0966 ● Fax: (952) 920-6098
E-Mail: cap@incnet.com Website: www.capsd.org

APPLICATION FOR MEMBERSHIP

Membership in the Council of Academic Programs in Communication Sciences and Disorders is open to all regionally or nationally accredited institutions of higher education that provide undergraduate and graduate education and offer academic degrees in communication sciences and disorders. Member institutions must comply with the Civil Rights Act, its amendments, and executive orders with respect to students, staff, and clients. (See Article VI of the Articles of Incorporation for complete information.)

This application for membership in the Council of Academic Programs in Communication Sciences and Disorders is hereby submitted in the name of the Institution specified below and is accompanied by a membership fee of \$350.00 that includes Council dues for the current year.

Dues year begins July 1 and ends June 30.

Applying Institution _____ Date _____

Program Title _____

Program Address _____

City _____ State _____ Zip _____

Telephone _____ Fax _____ Email _____

Program Website Address _____

This must be typed

Program Director _____ Ph.D. ___ Other(specify) _____

Program Representative to the Council (if different than name above). This person is the Council's official contact for your Program and is listed as such in the membership *Directory*.

Name _____ Ph.D. ___ Other(specify) _____

Address (if different than above) _____

Phone _____ Fax _____ Email _____

Program Clinic Director (if different than Program Representative).

Name _____ Ph.D. ___ Other(specify) _____

Address (if different than above) _____

Phone _____ Fax _____ Email _____

(Continued on reverse side)

Program Admissions Contact (if different than Program Representative).

Name _____ **Ph.D** ___ **Other(specify)** _____
Phone _____ **Fax** _____ **Email** _____

Multiple Campus Designation - If your program has a second campus in a different location, you may designate a person at this second location to also receive routine communications of the Council.

Name _____ **Ph.D** ___ **Other(specify)** _____
Address _____

Phone _____ **Fax** _____ **Email** _____

ACCREDITATION: List the state, regional, and/or national agencies that have accredited the institution and your program.

ASHA-CAA: _____ **SLP** _____ **A**
(Not applicable for programs in foreign countries or for programs that offer undergraduate degree only)
Other:

DEGREE MAJORS: Check the type of degrees offered by your program.

Major	Bachelors	Masters	Doctoral
Speech-Language Pathology	_____	_____	_____
Audiology	_____	_____	___PhD ___AuD
Speech & Hearing Science	_____	_____	_____

YOUR EXPECTATIONS: What do you hope to gain from membership in the Council?

CERTIFYING INSTITUTIONAL OFFICER: (Program Director/Department Chair)

Signature: _____
Printed Name: _____
Title: _____

Forward this completed Application for Membership form with dues payment to:

The Council of Academic Programs
P.O. Box 26532
Minneapolis, MN 55426

If institution accounting procedures require a separate invoice, return the completed Application For Membership and place an X here: _____



To assist you in remitting your dues (\$350), CAPCSD accepts Visa and Mastercard payments. You may also remit your dues with a check.

The credit card charge will appear on your statement from EAS, Inc., Executive Administrative Services, Inc.

Date _____ Fax Number _____

Name of Institution _____

Telephone _____

Card Type Visa ___ Mastercard ___

Card Number _____

Expiration date _____

Card authorization number (on back of card) _____

Card Billing Address _____

_____ Zip Code _____

Name on the card _____

Signature _____