

Independent Therapy Providers Association

A Trade Association Supporting Therapists in Private Practice



Membership Application

Please check which disciplines your company represents:

OT PT SLP

Other healthcare providers represented _____

I own one or more clinics I provide only home visits I provide services from my home

Total number of treating staff, employees or contractors: _____

Total number of patients treated/represented by your organization currently: _____

Organization/Clinic Name: _____

Web address: _____

Your Name (legal owner) _____ Position _____

Email _____

Please list up to two additional individuals in your organization you wish to be considered for membership. Only owners may be full members. Designated employees may be associate members on your behalf.

Name _____ Position _____

Email _____

Name _____ Position _____

Email _____

Organization correspondence information:

Address: _____

City, State, Zip: _____

Office Phone: () _____ Office Fax: () _____

Primary Service Location: Check here if the same as correspondence address

Address: _____

City, State, Zip: _____

Office Phone: () _____ Office Fax: () _____

Additional facility location:

Address: _____

City, State, Zip: _____

Office Phone: () _____ Office Fax: () _____

Additional facility location:

Address: _____

City, State, Zip: _____

Office Phone: () _____ Office Fax: () _____

Attach an additional list of locations to include all of your offices if more space is needed.

Membership oath is to be signed by each active member. Make copies as needed:

I certify that the information contained in my application is true and correct.

I further certify that as a member of this Association, I pledge to hold myself and my organization to the highest ethical standards in our industry. If my membership should terminate or be revoked for any reason, I agree to return any membership identification to the organization.

I agree to ensure membership dues for my organization are paid quarterly, due **January 15, April 15, July 15, October 15** of each year. These dates are firm regardless of when my Initial Member fees are paid.

Signature: _____ Date: _____

Printed name: _____

General Information

Please check any committees on which you are willing to serve:

- Governmental/Legislative Membership/ Recruitment Public Relations
- Reimbursement Ad Hoc Committees

Annual Dues are Per Tax ID entity enrolled, not per person/owner

Dues:

Initial New Member Fee - \$500 due at the time of application
Quarterly Dues - \$250

Mail this application and check payable to:

ITPA
PO Box 151509
Austin, TX 78715

Expedited Registration:

FAX completed and signed application to:
512-327-1545

Pay dues online using PayPal at:
www.joinitpa.com