



ASSOCIATION FOR APPLIED PSYCHOPHYSIOLOGY AND BIOFEEDBACK

2010 Membership Application

Please Print Clearly This address is a: Business Home Both **Referred By:** _____

Name: Dr. / Mrs. / Ms. / Mr. _____
First MI Last Degree/Suffix

Affiliation: _____

Title: _____ Office: () _____

Address: _____ Fax: () _____

Address: _____ Home: () _____

City: _____ State: _____ Zip: _____ Country: _____

E-mail: _____ Web: _____

Please provide the following information so that we may serve you better.

- | | |
|--|---|
| <p>1. Number of patients seen annually for biofeedback therapy:
 <input type="checkbox"/> Less than 25 <input type="checkbox"/> 101 - 499
 <input type="checkbox"/> 26 - 100 <input type="checkbox"/> 500 or more</p> <p>2. Highest degree earned: (check one)
 <input type="checkbox"/> Associate <input type="checkbox"/> Other Masters <input type="checkbox"/> PsyD
 <input type="checkbox"/> BA/BS <input type="checkbox"/> PhD <input type="checkbox"/> DDS
 <input type="checkbox"/> MA <input type="checkbox"/> MD <input type="checkbox"/> DO
 <input type="checkbox"/> MS <input type="checkbox"/> EdD <input type="checkbox"/> MD/PhD
 <input type="checkbox"/> MSW <input type="checkbox"/> DC <input type="checkbox"/> Other</p> <p>3. Percent of time spent in biofeedback each year:
 <input type="checkbox"/> < than 10% <input type="checkbox"/> 11%-40% <input type="checkbox"/> > than 40%</p> <p>4. What is your primary type of practice?
 <input type="checkbox"/> Private/Independent <input type="checkbox"/> Group <input type="checkbox"/> Hospital</p> <p>5. Are you licensed to practice independently in a health care field?
 <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Discipline: (check one)
 <input type="checkbox"/> Psychology <input type="checkbox"/> Nursing
 <input type="checkbox"/> Medicine <input type="checkbox"/> Social Work
 <input type="checkbox"/> Dentistry <input type="checkbox"/> Counseling
 <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Education
 <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Pathology
 <input type="checkbox"/> Chiropractic <input type="checkbox"/> Other</p> <p>7. What year did you start offering biofeedback services in practice?
 _____</p> <p>8. Do you see patients for clinical biofeedback treatment?
 <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you offer services under supervision, i.e., are you supervised by a licensed independent practitioner?
 <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>10. Primary area of biofeedback activity:
 <input type="checkbox"/> Clinical <input type="checkbox"/> Clinical/Research
 <input type="checkbox"/> Research <input type="checkbox"/> Education</p> <p>11. From what institution did you receive your highest degree?
 _____</p> <p>12. What Year was your highest degree received? _____</p> <p>13. Check up to 5 areas of specialty for biofeedback.
 <input type="checkbox"/> 1. Anxiety disorders
 <input type="checkbox"/> 2. Behavioral: work/drug/alcohol/smoking/weight
 <input type="checkbox"/> 3. Bruxism <input type="checkbox"/> 4. Diabetes
 <input type="checkbox"/> 5. Educational applications <input type="checkbox"/> 6. Epilepsy
 <input type="checkbox"/> 7. Fecal incontinence <input type="checkbox"/> 8. OB/GYN
 <input type="checkbox"/> 9. Pain <input type="checkbox"/> 10. Psychotherapy
 <input type="checkbox"/> 11. Sexual disorders <input type="checkbox"/> 12. Sleep disorders
 <input type="checkbox"/> 13. Speech disorders <input type="checkbox"/> 14. Sports applications
 <input type="checkbox"/> 15. Stress management <input type="checkbox"/> 16. Urinary incontinence
 <input type="checkbox"/> 17. Cancer related disorders <input type="checkbox"/> 18. EEG applications
 <input type="checkbox"/> 19. Stress related (psychosomatic disorders): asthma, blepharospasm, dermatitis, dysmenorrhea, essential hypertension, migraine and tension headache, hyperhidrosis, insomnia, irritable bowel syndrome, myofascial pain, psychogenic emesis, Raynauds disease/syndrome, tic, tinnitus, vascular headache, writers cramp.
 <input type="checkbox"/> 20. Physical therapy/neuromuscular rehabilitation: causalgia, cerebral palsy, esophageal motility disorders, dysphagia, Guillian Barre syndrome, hemiplegia, M.S., orthopedics, paretic muscles, Parkinson's disease, respiratory disorders, spinal cord injuries, stroke, tendon transfer, tic, torticollis.
 <input type="checkbox"/> 21. Pediatric (Children): hyperkinesis, learning disabilities.</p> |
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Over Please for Payment Information

AAPB MEMBERSHIP CATEGORIES:

All Categories include a subscription and online access to the *Applied Psychophysiology & Biofeedback* journal and online access to the clinical journal *Biofeedback* and *The Journal of Behavioral Medicine*.

Regular Member: Persons engaged in the scientific and professional advancement of applied psychophysiology and biofeedback or related fields. Full members are required to hold an advanced degree, or the equivalent entry level degree, from an accredited school for the specific discipline in which the individual practices, does research or teaches.

Associate Member: Persons who are interested in applied psychophysiology and biofeedback or related fields and who do not meet the necessary requirements for full membership.

Corresponding Member: Open to international members (excluding Canada). Entitles members to electronic versions only of the journals. Non-voting member. Member rates to attend Annual Meeting and Workshops. Email Required.

Student Member: Full-time students enrolled in an accredited training institution as documented by a copy of the student ID.

Corporate Member: Open to suppliers and corporations supporting AAPB. Receive 10% discount on advertising, extra points for exhibit booth placement at the Annual Meeting, corporate acknowledgment on the AAPB web site with free web link and listing in AAPB publications.

Corporate Clinical Member: Open to clinics that provide applied psychophysiology, biofeedback/neurofeedback and related services. Includes one full membership with right to vote and hold office. Up to five listings in the provider directory with discounted rates for all members of the corporation to the AAPB annual meeting or educational events.

A. MEMBERSHIP DUES SCHEDULE: Select only one Membership Category.

- \$180 Regular Member
- \$180 Associate Member
- \$65 Corresponding Member (See description)
- \$55 Student Member (Copy of student ID required!)
- \$650 Corporate Member
- \$420 Corporate Clinical Member

A. MEMBERSHIP DUES SUBTOTAL:* _____

B. BIOFEEDBACK CLINICAL JOURNAL : \$30 Printed Version
Access to online searchable version is included in membership.

B. PRINTED JOURNAL:* _____

C. PROVIDER DIRECTORY LISTING: One year listing on AAPB website \$50 **C. PROVIDER DIRECTORY LISTING:*** _____

D. SECTION/DIVISION MEMBERSHIP: You MUST be an AAPB Member to join a section or division.

- \$10 Allied Professional Section
- \$15 Applied Respiratory Psychophysiology Section
- \$15 Child and Adolescent Health
- \$10 Education Section
- \$10 International Section
- \$15 Mind-Body Medicine Section
- \$25 ISMA-US Stress Management Section
- \$20 \$50 Neurofeedback Division - Regular or Sustaining
- \$15 Optimal Functioning Section
- \$10 Performing Arts Psychophysiology Section
- \$15 sEMG/SESNA Division

D. SECTION MEMBERSHIP SUBTOTAL:* _____

E. MEMBER VERIFICATION: You may purchase a certificate verifying your AAPB Membership, suitable for framing.
 \$15 Membership Certificate

E. MEMBER CERTIFICATE:* _____

F. FUND FOR THE FUTURE: Voluntary contribution.
 \$25 \$50 \$75 \$100 \$_____

F. FUND FOR THE FUTURE SUBTOTAL:* _____

G. FEDERATION DUES: Voluntary contribution.

Do you spend more than 50% of your time in research related to applied psychophysiology? Yes No
If yes, would you be willing to contribute Federation dues? \$12.25

F. FEDERATION DUES:* _____

H. AAPB FOUNDATION:

- \$30 \$60 \$100 \$250 \$1000 \$_____

H. AAPB FOUNDATION SUBTOTAL:** _____

AAPB occasionally makes the membership list available to companies and associations in the industry.
If you would like your name withheld from these mailings, please check this box:

By submitting my membership dues, I agree to abide by the Ethical Principles of AAPB.

PAYMENT INFORMATION: Check/Money Order Visa MasterCard Amex

Card Number: _____ Exp. Date: _____

Name on Card: _____ 3 Digit CVV Code _____

Signature: _____

Return this form with your payment. Checks or money orders (in U.S. dollars) payable to AAPB.
10200 West 44th Avenue, Suite 304, Wheat Ridge, CO 80033-2840, USA
Credit Card Payments can be faxed to AAPB at 303-422-8894.

SUM A → H: _____

TOTAL DUE: _____

* Payments to AAPB are not tax deductible as charitable contributions, although they may be tax deductible as a business expense. Consult your tax advisor.
** Payments to the AAPB Foundation ARE tax deductible as charitable contributions.