MAMFT MEMBERSHIP APPLICATION

We Are Excited to Have You!

**Please mail completed application and payment (check payable to MAMFT) to address listed below. Register online beginning June 1, 2018 at www.mamft.com

Name: ____

Address: ____

____

Phone: ____

Email: ____

License Number: ____________________ Type of License: __________________

Birthdate: ___________________ Gender: ____________

Race/Ethnicity: ____________________

Graduation Date (past or expected): ________________

Level of Membership:

____ Clinical Member ($100) ____ Clinical Associate Member ($50)

____ Affiliate Member ($100) ____ Student Member ($25)

____ Recently Renewed Member of AAMFT and MAMFT prior to May 1st, 2018 (Provide receipt of payment for recent renewal from AAMFT)

P.O. BOX 16494, HATTIESBURG, MS 39404 | MAMFT.COM
MAMFTEXECUTIVEDIRECTOR@GMAIL.COM