

# DCA

DADE COUNSELING ASSOCIATION  
www.dadecounselingassn.com  
APPLICATION FORM  
OCTOBER IS RENEWAL MONTH

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_\_

New Member?  Yes  No Please print your name, as you would like it to appear on the certificate:

\_\_\_\_\_

FCA Member?  Yes  No  
ACA Member?  Yes  No

FSCA Member?  Yes  No  
ASCA Member?  Yes  No

Mailing Address: \_\_\_\_\_ Apt.: \_\_\_\_\_

City: \_\_\_\_\_ Zipcode: \_\_\_\_\_

Preferred E-mail Address: \_\_\_\_\_

Evening Phone: \_\_\_\_\_ Day Phone: \_\_\_\_\_

Work Location: \_\_\_\_\_ Job Title: \_\_\_\_\_

Please select events you may be interested in helping to plan or volunteer for:

Newsletter  Student Services Breakfast  Awards  Multicultural Dinner  Community Service

Professional Development

Membership Dues:  
(Make checks payable to DADE COUNSELING ASSOCIATION)  
**One Year .....\$20**

## FOR OFFICE USE ONLY

Received	
Input	
Sent	
Check#	
Expires	

**Retiree Dues.....\$15**  
**Student Dues.....\$15\*\***  
**\*\*Certification by major instructor required.**

\_\_\_\_\_  
Professor's Name

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Name of Institution

I certify that the applicant is engaged in studies in counseling or the human services area.

\_\_\_\_\_  
Professor's Signature

**Send application to: D.C.A. \* P.O. Box 160925 \* Miami, Fl.33116**