Contact Person

First Name _________________________ Last Name _____________________________ Designations ___________

Title ______________________________

Job Classification:  □ CEO/President  □ Supervisor  □ Program Manager  □ Direct Service  □ Admin Staff
                      □ Researcher  □ Educator  □ Peer Support Provider  □ Other ________________

Organization Information

Name ______________________________________________________________________________________

Address ______________________________________________________________________________________

City ___________________________ State/Province _________ Postal Code _________ Country __________

Primary Phone _________________________ Primary E-Mail Address _________________________________

Newsletters, alerts, and updates are transmitted electronically,

Membership Types and Rates

□ Individual ($125) – Individuals who are in the field of psychiatric rehabilitation or related fields, people in recovery, family members of people in recovery – **Note: you can also sign up for an individual membership on our website**

□ Strategic Partner ($650) – Colleges, universities, bookstores, membership organizations, trade associations or other organizations that DO NOT provide direct service.

□ Veterans Administration* ($395) – Facility locations for the US Department of Veterans Affairs.

□ Organizational Membership* (rate is based on psych rehab program budget) – Organizations demonstrating a commitment to quality standards and leadership in the field of psychiatric rehabilitation through the provision of recovery-oriented services. Select budget:

□ $225 (below $100K)  □ $400 ($100 - $200K)  □ $555 ($200 - $500K)
□ $1110 ($500K - $1M)  □ $1595 ($1 – $2M)  □ $2395 ($2 – $3M)
□ $2770 ($3 – $4M)  □ $3265 ($4 – $5M)  □ $3740 ($5 - $6M)
□ $4070 ($6 - $7M)  □ $4485 ($7 - $8M)  □ $5190 ($8M+)

*Includes member benefits for employees with linked accounts on the PRA website.
Payment Information

☐ USD Check (Payable to PRA)  Check # ____________________________

☐ Credit Card
  ☐ Visa    ☐ MasterCard    ☐ Discover    ☐ American Express

Card Number  ________________________________

Exp (mm/yy)  ______/_______  CCV: ______________________

Name on Card  ________________________________  Billing Zip/Postal Code _________

Signature  _______________________________________

Submit Completed Application by Mail or Email:

info@psychrehabassociation.org

Psychiatric Rehabilitation Association

212 E. LaSalle Avenue

Suite 220

South Bend, IN 46617