



Membership Application

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:

- | | | |
|---|---|---|
| <input type="checkbox"/> \$225 (below \$100K) | <input type="checkbox"/> \$400 (\$100 - \$200K) | <input type="checkbox"/> \$555 (\$200 - \$500K) |
| <input type="checkbox"/> \$1110 (\$500K - \$1M) | <input type="checkbox"/> \$1595 (\$1 - \$2M) | <input type="checkbox"/> \$2395 (\$2 - \$3M) |
| <input type="checkbox"/> \$2770 (\$3 - \$4M) | <input type="checkbox"/> \$3265 (\$4 - \$5M) | <input type="checkbox"/> \$3740 (\$5 - \$6M) |
| <input type="checkbox"/> \$4070 (\$6 - \$7M) | <input type="checkbox"/> \$4485 (\$7 - \$8M) | <input type="checkbox"/> \$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