International Academy of Collaborative Professionals &
Collaborative Practice Institute of Michigan

Joint Membership Application

COLLABORATIVE PRACTICE INSTITUTE of MICHIGAN
Resolving Disputes Respectfully

Collaborative Practice Institute of Michigan membership is open to attorneys, financial professionals, mediators, and mental health professionals who are certified in their professional organizations, have completed at least a two-day interdisciplinary training in collaborative practice, and can certify they have malpractice coverage. Membership in IACP is required for membership in CPIM and included in your Whole Group Membership fee.

❒New Member ❒Renewal

1. MEMBERSHIP INFORMATION:

First Name Middle Initial Last Name

Business/Firm Name

Office Address ☐ check here if same as billing address

City State Zip Code County

Telephone Fax

Email (required) Website

Profession(s) (**Options for website listing are: attorney, mediator, child specialist, divorce coach, financial specialist, mental health professional.)

Billing Address (if paying by credit card and different from above)

City State Zip Code County

2. ❒ (New members) I certify that I have completed a two- or three-day Interdisciplinary Collaborative Practice Training and have attached proof to this document**. Date of Training: _____**

3. ❒ I certify that I have current professional liability/malpractice insurance coverage and have **attached** proof to this document.

4. ADDITIONAL INFORMATION:

❒ I prefer **not** to be included on a mailing list for vendors who provide products and services to the collaborative community.

5. MEMBERSHIP FEES:

❒ I have included payment of $240 for my annual dues. (This entitles you to membership in both CPIM **and** the International Academy of Collaborative Professionals.)

IACP Whole Group Membership	$145.00 USD
CPIM Membership	$95.00 US

6. PAYMENT:

❒Check (make payable to CPIM)
❒Credit Card: ___VISA ____MasterCard
Card No.: _____
Exp. Date: _____ CVV Number _____
Name on Account: _____
Amount Charged: $_____Zip Code_____
Signature _____

7. IACP AGREEMENT:

By becoming an IACP member and signing this application, I agree to honor the IACP Standards* for Practitioners, Trainers and Trainings. I further agree to abide by the License Agreement* relative to the use of the Collaborative Practice/Collaborative Law Practice "Mark."

By becoming an IACP member, you give IACP permission to contact you periodically via e-mail, postal service or telephone regarding matters of importance to the Collaborative community.

*Copies of the Standards, License Agreement and Guidelines for Use can be found on the IACP Website at www.collaborativepractice.com

Signature

Date

COLLABORATIVE PRACTICE INSTITUTE OF MICHIGAN
333 Bridge Street NW, Suite 1020
Grand Rapids, Michigan 49504
Phone: (616) 608-7514 Fax: (616) 233-9166

What CPIM team(s) would you be interested in joining?

❒Basic Training ❒Advanced Training
❒Public Communication ❒Website
❒Quality Assurance ❒Membership
❒Fundraising ❒Social Media