

APPLICATION FOR AFFILIATION AS A CLANH MEMBER ATTORNEY MEMBER

**Before completing application please see CLANH Minimum Standards located at
www.collaborativelawnh.com**

SECTION 1: CONTACT INFORMATION

NAME: _____

FIRM NAME (if applicable): _____

ADDRESS: _____

PHONE: _____ EMAIL: _____

WEBSITE: _____

SECTION 2: ATTORNEY MEMBER APPLICATION

Attorney Member requirements:

- Member in good standing in a state bar association;
- Support for the principles of Collaborative Practice;
- Completion of a minimum level of training in Collaborative Practice (12 hours of Interdisciplinary Collaborative training);
- A history for maintaining high ethical standards;
- Intent to be available to provide Collaborative Practice services;
- Payment of annual dues;
- Compliance with continuing education standards.

If you don't meet membership requirements please consider joining as a "Supporter"

Information about your professional accreditation:

Please list the following:

1. The states where you are licensed to practice law;
2. Date of each bar admission; and
3. Bar identification numbers, if applicable.

Briefly describe your background experience in the practice of law including information as to your areas of practice:

Information about your collaborative training:

Date, location and sponsoring organization of your training in Collaborative dispute resolution:

If this training was not sponsored by CLANH please attach a copy of your certificate of attendance.

Disciplinary history: initial below

Has any disciplinary action been taken against you within the past 5 years by a professional regulatory or certifying organization in any jurisdiction? _____yes _____ no. If yes, please explain in detail including the date, jurisdiction and name of governing body.

Please initial below that you will abide by the following general requirements for Collaborative Professionals:

_____ I agree to be a member in good standing of CLANH, and to comply with the Minimum Standards;

_____ I accept the IACP Mission Statement; and

_____ I will strive to practice in a manner consistent with the IACP Principles of Collaborative Practice and the IACP Ethical Standards for Collaborative practitioners.

I certify that the information contained herein is true and accurate.

Date: _____

Signature: _____

Please mail your application to: CLANH, PO Box 803, Londonderry NH 03053.

Thank you!