



Membership Registration and Renewal Form

Directions:

Please complete this fill-able form and submit as directed at the end. Section 1 is for your agency to renew membership and identify the person to receive the invoice to follow. Do not submit payment with the return of this form as CLINIC will submit an invoice in the amount indicated below sent to your designated accounts payable person.

Section 2 asks for your agency's agreement in upholding CLINIC's Core Standards for Charitable Immigration Programs and the Terms and Conditions contained within the Membership Agreement. Please check your agreement with both documents.

Section 3 asks for updated information about your agency, immigration program and staff so that CLINIC's databases are accurate and legal immigration legal staff are designated to access CLINIC's services.

Section 1. Membership Fees

| 2010 Program Budget | Membership Fee | check appropriate box |
|-----------------------|----------------|-----------------------|
| Less than \$50,000 | \$600 | |
| \$50,001 to \$150,000 | \$800 | |
| \$150,001 and up | \$1000 | |

Please provide contact information for the person responsible for accounts payable for future invoices:

Name: _____ Position: _____ Tel: _____

Street Address: _____ City: _____ State _____ Zip Code: _____

Email: _____ Phone: _____

Section 2. Acceptance of CLINIC's Core Standards and Membership Agreement

CLINIC seeks to constantly expand and improve the quality of charitable immigration legal services. As an integral part of that effort, CLINIC has [Core Standards for Charitable Immigration Programs](#). We hope you will review the standards and work to implement and sustain them in your program.

Box I accept CLINIC's Core Standards for Charitable Immigration Programs

As part of the renewal process, please read and accept the terms and conditions of membership in the [Membership Agreement](#). Certain policies have been established which may have significant consequences for your immigration program.

Box I accept the terms and conditions of CLINIC's Membership Agreement

Section 3. Information about the Parent (Headquarters) Agency

Please provide CLINIC with the most up-to-date information about your agency, immigration program and staff so CLINIC's databases are current and your program staff receives member services.

Name: _____ (Arch)diocese: _____

Mailing Address: _____

Tel: _____ Fax: _____ Website: _____

Executive Director's Name: _____ Honorifics: _____

E/D Email: _____ E/D Tel: _____

Information about the Immigration Program

Immigration Program's Name: _____

Mailing Address: _____

Tel: _____ Fax: _____ Website: _____

Program Director's Name: _____ Tel: _____ Email: _____

Is the program director the primary contact person? Select Yes or No

If no, please list the name of the primary contact person: _____

Legal Authorization Status: BIA Recognition Yes No Attorney on staff

Type of Immigration Services Provided (Check all that apply):

Family-based immigration

Refugee-based immigration

Naturalization and citizenship

English as a Second Language (ESL) classes

ESL/civics-naturalization classes

Naturalization interview and test preparation classes

Religious visas

