



## Subscriber Registration Form

### Directions:

Please complete this fill-able form and submit as directed at the end. Section 1 is for your agency to renew subscription 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 for \$1,500 to your designated accounts payable person indicated below.

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 Subscription 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. Subscriber Dues Payment

**Subscription dues are \$1,500 for 2012 to be paid in full upon receipt of an invoice.**

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

Name: \_\_\_\_\_ Tel: \_\_\_\_\_

Street Address : \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

### Section 2. Acceptance of CLINIC's Core Standards and Subscription 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 expect 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 subscription provided in the [Subscription 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 Subscription 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 subscription services.

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_ Website: \_\_\_\_\_

Executive Director's Name: \_\_\_\_\_ Honorifics: \_\_\_\_\_

E.D.'s Email: \_\_\_\_\_ E.D.'s 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

VAWA, T and U visas (services to survivors of crimes, violence and sexual assault)

Asylum

Immigration raids and enforcement response

\_\_\_\_ Relief from removal

\_\_\_\_ Detention-based services

\_\_\_\_ Other: (fill in the blank)

Hours of Operation:

\_\_\_\_\_

### Immigration Program s Staff Information

Name	Position and Credentials (BIA, Esq., other)	Email	Telephone and ext.

### Immigration Program s Suboffice 1 *if applicable*

# of sub-offices \_\_\_\_\_ (complete information for each sub-office below)

1. Sub-Office's name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_ Website: \_\_\_\_\_

Hours of Operation: \_\_\_\_\_

Legal Authorization Status: BIA Recognition \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Attorney on staff:

**Staff Information:**



