

**FORM 10**

**New Clinical Member Form**  
Sandplay Therapists of America

Candidate completed requirements for clinical membership on \_\_\_\_\_  
Day/Month/Year

**Advisor Information:**

Advisor's Name \_\_\_\_\_

E-mail address or phone number \_\_\_\_\_

Advisor's signature \_\_\_\_\_

**Clinical Member Information:**

Clinical Member's Name \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_

State/Providence \_\_\_\_\_ Post code \_\_\_\_\_

Country \_\_\_\_\_

Business Phone Number \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

E-mail Address \_\_\_\_\_

**Reader Information:**

Reader No. 1 \_\_\_\_\_

Reader No. 2 \_\_\_\_\_

Reader No. 3 \_\_\_\_\_

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Please send the completed form to:

**STA**  
**PO Box 4847**  
**Walnut Creek, CA 94596**  
**925/687-9985**

Or fax to:

**A copy of this form will be forwarded to ISST**

See Chapter Four and Appendix A17/1-4 for more information.