

## RESIDENT ACTIVITY PERSONNEL in OHIO (RAP) MEMBERSHIP APPLICATION

RAP is a statewide organization for activity personnel in Ohio. It was conceived and organized by representatives of the activity profession from across the state.

### ACTIVE MEMBERSHIP (\$24 FOR 2 years)

Active Membership is for personnel employed in activity programming, full or part-time, including consultants, social workers, and anyone directly or indirectly playing an active role in activity program. Active members constitute the voting members

### ASSOCIATE MEMBERS (\$12 for 2 years)

Associate Membership is for those having contact with activity programming, including students, senior citizens, volunteers, retired activity professionals, and anyone else interested in activity in activity programming. Associate Members are non-voting members.

### BENEFITS

- Annual Conference Discount
- Quarterly Newsletters
- Association with other Activity Professionals
- Opportunity to contribute suggestions, comments, concerns and objections to RAP Board of Trustees
- Access to the RAP office, Board Members, District Representatives for all the current information in the Activity and Social Services Professional fields.
- Laminated Membership Card

If you move or change facilities please advise the RAP office ASAP by fax, phone or e-mail.

FAX: 513-932-7369 **Phone: 513-932-5963** e-mail: [rapinohio@yahoo.com](mailto:rapinohio@yahoo.com)

PLEASE MAIL Completed Form and check (payable to RAP in Ohio) to:

RAP in Ohio  
491 St. Rt. 741, Room 204  
Lebanon, OH 45036



New Membership       Renewal Membership   
Type of Membership: Active  \$24.00      Associate  \$12.00

NAME \_\_\_\_\_ Home Phone Number \_\_\_\_\_  
Home Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
E=Mail Address @ Home \_\_\_\_\_

I DO NOT WANT MY MAILING ADDRESS RELEASED TO OTHER AGENCIES

Place of Employment: _____		e-mail: _____	
Facility Address _____		City/State/Zip _____	
Facility Phone (____) _____		Fax: (____) _____	
County: _____		Position/Title _____ # of Years _____	
Credentials _____		Number of Beds in Facility _____	
Long-term Health Care <input type="checkbox"/>		Assisted Living <input type="checkbox"/>	
Senior Retirement <input type="checkbox"/>		Adult Day Services <input type="checkbox"/>	
Senior Center <input type="checkbox"/>		MRDD Services <input type="checkbox"/>	
		Other <input type="checkbox"/>	

**(OFFICE USE ONLY)** Check # \_\_\_\_\_ Amount: \_\_\_\_\_ Business or Personal