## American Psychological Association

## **Committee on Early Career Psychologists (CECP)** 2014 Nomination/Leadership Form

The following information will be used for internal APA purposes only to process your CECP nomination and/or include you in a database of early career members who have expressed an interest in receiving information about future APA leadership opportunities. Email the completed form with your nomination or achievement award application to Sonja Wiggins at earlycareer@apa.org

| APA Membership Number:                  |   | Date:                          |                                     |  |
|---|---|--------------------------------|-------------------------------------|--|
| SECTION I<br>Name: First                |   | _Last                          | Initial                             |  |
| Institution (if applicable)             |   |                                |                                     |  |
| Street Address                          |   |                                |                                     |  |
| City                                    |   | State                          | Zip                                 |  |
| Email                                   |   | Year you earned your doctorate |                                     |  |
| Mobile #                                | Home #  |                                | Work #                              |  |
| SECTION II<br>Have you ever attended ar | ny of the following (se   | elect all that anniv           |                                     |  |
| -                                       | APA Annual Convention   |                                | APA State Leadership Conference     |  |
| APA Division Lead                       | APA Division Leadership Conference                              |                                | APA Education Leadership Conference |  |
| Have you ever held a lead               | ership position in AP   | A, an APA Division,            | or your state psychological asso    |  |
| Yes                                     |   | No                             |                                     |  |
| State association membersh              | s):   |                                |                                     |  |
| Research                                | ease indicate your PRIMARY work activity (see<br>Research Educa |                                | Mental/Health Services              |  |
| Applied Psycholog                       |   | gement/Administration          | on                                  |  |
| Please indicate your PRIM               |   |                                |                                     |  |
| University/4-Yr College                 |   | Medical                        | Medical School/Medical Center       |  |
| Schools/Other Academic Settings         |   | Indepen                        | Independent Practice                |  |
| Hospital/Hospice                        |   | Clinic                         | Clinic                              |  |
| Human Services                          |   | Busines                        | Business/Industry                   |  |
| Human Services                          |   |                                |                                     |  |

<u>select only one</u> (Note: this form must be submitted with your application):

Education and Training Representative` Practice Representative Governance and Membership Representative Science Representative

Public Interest Representative Division Representative

State Representative (SPTA)