



HAWAII SOCIETY OF CERTIFIED PUBLIC ACCOUNTANTS
 900 Fort Street, Suite 850
 P.O. Box 1754 • Honolulu, Hawaii 96806
 Tel: (808) 537-9475 • Fax: (808) 537-3520 •
 hscpa@aloha.net

ASSOCIATE

Application Date _____

1. Name (Print) _____ M/F _____ Home Phone () _____
2. Residence Address _____

3. Name of Firm/Company _____ Business Phone () _____
Address _____ Fax Number () _____
_____ E-Mail _____
4. Position / Title _____
5. Please indicate address to be used for mail: Residence _____ Business _____
6. Place of Birth _____ Date of Birth _____
7. Married: Yes () No () If married, spouse's name _____
8. State of Examination _____ Date Passed _____
9. University / College Attended _____
10. Membership in Professional, Civic or Social Organizations _____

11. **Applicant's Statement:** To the best of my knowledge and belief, the information contained herein is true and correct. If elected to associate membership, I agree to be governed by and comply with the Constitution and Bylaws of the HSCPA.

It is understood that my membership will be changed to REGULAR status at the time of certification and that I will so notify the HSCPA when certification has been received.

Signature _____ Date _____

Print name as you wish it to appear on membership certificate:

12. **Sponsor's Statement:** We are members in good standing of the HSCPA and personally acquainted with the applicant and recommend him/her for membership.

Signature _____ Date _____

Print Name _____

Signature _____ Date _____

Print Name _____

**Initiation Fee of \$25.00
must accompany application.**

**Please submit a photograph,
preferably black & white.**

For HSCPA Office Use Only:			
Date Received	HSCPA No.	Board Approval	Verification