HSCPA

Visit us at:
www.hscpa.org

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 • E: info@hscpa.org

REGULAR

☐ **Resident** ☐ **Resident (Neighbor Island)** ☐ **Mainland** ☐ **International** ☐ **Reinstatement** ☐ **Reclassify**

***Optional - Important for communication and special mailing purposes** 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. Employment Area: Public Accounting ____Business & Industry____Education____Government____Other (specify)_____
6. Please indicate address to be used for mail: Residence_____ Business_____
7. Place of Birth_____ ***Date of Birth**_____
8. For member benefits purpose: Married: Yes ( ) No ( ) If married, spouse's name_____
9. State of Original Certification_____ Certificate No._____ Date Issued_____
10. Hawaii Certificate No._____Date Issued_____
11. University / College Attended and Degree(s) Earned _____
12. Membership in Professional, Civic or Social Organizations_____ AICPA No._____

13. **Applicant's Statement**: To the best of my knowledge and belief, the information contained herein is true and correct. I also certify that I hold a valid and unrevoked certified public accountant certificate (or foreign country equivalent). If elected to membership, I agree to be governed by and comply with the Constitution and Bylaws of the Hawaii Society of CPAs (HSCPA).

    I understand that by providing the fax number(s) and/or e-mail address above, I hereby consent to receive faxes and/or e-mails sent by or on behalf of the HSCPA, unless otherwise indicated.

    Signature_____Date_____

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

    _____

14. **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 / Reinstatement Fee of $25.00 must accompany application.

Please submit a photograph, preferably black & white (optional).

*To help us better serve you, please tell us why you choose to be a member of the HSCPA.*_____

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

CPA℠ America Counts on CPAs