



INDEPENDENT POOL & SPA SERVICE ASSOCIATION, INC.

New Member Checklist

Chapter Name

Date

New Member Name

Application (signed)

Has Member:

Attended three meetings

Passed Water Chemistry Exam

Autopay Form (optional)

Check to IPSSA Inc.:

First Month	\$
Second Month	\$
New Member Packet	\$ <u>15.00</u>
Total to IPSSA Inc. :	\$

Check to Chapter:

Chapter Initiation Fee	\$
Book Purchases	\$
Other	\$
Other	\$
Other	\$
Total to Chapter:	\$



INDEPENDENT POOL & SPA SERVICE ASSOCIATION, INC.

PO BOX 254645
SACRAMENTO, CA
95865
888-360-9505
888-368-0432 (FAX)
memberservices@ipssa.com

MEMBERSHIP APPLICATION (Rev. 1/2022)

NAME	COMPANY NAME
HOME ADDRESS	COMPANY ADDRESS
HOME CITY/STATE/ZIP	COMPANY CITY/STATE/ZIP
HOME TELEPHONE	BUSINESS TELEPHONE
MOBILE TELEPHONE	FAX NUMBER
EMAIL ADDRESS	DATE OF BIRTH

Are you a self-employed independent pool and/or spa technician and not an employee of any other pool and/or spa technician or company?

Yes No

Do you derive more than 50% of your business income from pool and/or spa maintenance and/or repair:

Yes No

Number of years in pool service/ repair business	Number of pools on service	If you are covered with temporary insurance, indicate the date your insurance lapses
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Have you been an IPSSA member before and are
rejoining?

If yes, please list the chapter

As a new member you have up to one year to take these courses and show proof and provide proof by sending to info@ipssa.com. The courses listed are acceptable as a membership requirement. Please verify with your chapter president on which courses are allowed.

IPSSA Water Chemistry Exam	CPO - Certified Pool Operator
PPSO - Professional Pool & Spa Operator	LA County Health Department License
PCCR - Pool Chemistry Certified-Residential	Florida Registered/Certified Contractor Pool & Spa Exam

Insurance Requirement

I want the business liability insurance plan and life insurance offered by Arrow Insurance Service (payments will be made directly to Arrow Insurance for these coverages.)

YES NO

By signing below, I understand my membership will not take effect until the IPSSA Inc. office receives (a) a certificate of insurance that meets IPSSAs minimum requirements, and (b) the certificate names IPSSA as an additional insured and (c) insurer contact information is provided.

Insurer Policy Number

Contact Name at Insurer Telephone

I declare that the above is true and correct. I agree to comply with IPSSA bylaws, standing rules and policies and procedures. I understand the liability insurance must be carried for all employees and that all subcontractors must carry a minimum of \$1,000,000 in liability insurance. Furthermore, I agree to submit to binding arbitration in all grievances filed with IPSSA.

Membership goes into effect the first of the month after the IPSSA Inc. office receives the membership application from the IPSSA chapter and verifies that all membership requirements have been met.

Do you wish to have your dues payments automatically debited from your bank account or credit card? If yes, complete and send the automatic payment form and fax it to: 888-368-0432.

Yes No

SIGNATURE

DATE

For Chapter Use Only: Chapter

Date application received

Sponsored by

Authorized by (signature)

Print Name

Chapter Title

Date

For IPSSA Inc. Use Only: Processed _____ **Start Date** _____ **Account #** _____ **First Moth** _____ **Secnod Month** _____



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EMPLOYEE MEMBERSHIP APPLICATION
(Rev. 1/2022)

EMPLOYER INFORMATION

NAME Account Number

If there have been changes to your company information, please fill in the information below:

COMPANY NAME

COMPANY ADDRESS

COMPANY CITY/STATE/ZIP

BUSINESS TELEPHONE

MOBILE TELEPHONE

EMAIL

FAX NUMBER

Is the current employee being dropped?

If yes, name and account number of employee being dropped

Yes No

NEW EMPLOYEE INFORMATION

Name

Date of Birth

Name

Date of Birth

Describe any lawsuits or insurance claims filed against you in the past five years in connection with pool/spa maintenance or repair

By signing below, I understand the employee membership will not take effect until the IPSSA Inc. office receives (a) a certificate of insurance that meets IPSSAs minimum requirements, and (b) the certificate names IPSSA as an additional insured and (c) insurer contact information is provided.

Insurer

Policy Number

Contact Name at Insurer

Telephone

Insurance certificate is attached

Yes

No, it has been requested from my insurer

I declare that the above is true and correct. The undersigned hereby applies for membership in IPSSA as an Employee Member, subject to the bylaws, standing rules and other policy statements of IPSSA governing such membership. The undersigned understands that only employees of Regular IPSSA Members may qualify to be Employee Members and only for so long as they remain employees of the Regular Member. Furthermore, the Employee Member must be sponsored by the Regular Member and must meet qualification requirements established by IPSSA. The undersigned acknowledges that IPSSA membership as an Employee Member is totally discretionary with IPSSA and may be revoked or terminated at any time. Furthermore, I agree to submit to binding arbitration in all grievances with IPSSA.

Employee Members who have met all chapter requirements shall become effective on the first day of the month the requirements are met so long as the membership documents are received by the IPSSA Inc. office by the 15th of the month.

EMPLOYEE SIGNATURE

DATE

EMPLOYEE SIGNATURE

DATE

For Chapter Use Only:

Chapter

Start Date

Approved by (signature)

Print name

Chapter Title

Date

For IPSSA Use Only:

Processed.....Start Date.....Account #.....Owner ID#First Month.....Second Month.....Member type



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TRANSFER OF CHAPTER MEMBERSHIP (Rev. 1/2022)

Date form submitted

Completed forms should be mailed to:

IPSSA, Inc.
PO Box 254645
Sacramento, CA 95865-4645
Or email to memberservices@ipssa.com

IPSSA MEMBER NAME

IPSSA Member Number

I certify this information is true and correct. I agree to comply with IPSSA bylaws, standing rules and policies and procedures. I understand that liability insurance must be carried for all employees and that all subcontractors must carry a minimum of \$500,000 in liability insurance. Furthermore, I agree to submit to binding arbitration in all grievances with IPSSA. **Note: The member's account must be paid in full before the transfer can be processed.**

Signature

Transfer from (Chapter Name)

Effective Date of Transfer

Approved by Chapter Officer (Name)

Chapter Officer Title

Signature of Chapter Officer

Date signed

Transfer to (Chapter Name)

Approved by Chapter Officer (Name)

Chapter Officer Title

Signature of Chapter Officer

Date signed

For IPSSA Use Only:

Processed by:

New Account #

Date



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Would you like to automate your monthly dues payment?

(Rev. 1/2022)

With your authorization, IPSSA can automatically debit your bank account for your monthly dues owed to IPSSA.

+The debit will be made on the 1st of each month for the current month..

+There is no charge for this service by either IPSSA or your bank unless there are not funds available in your account when the charge is presented for payment.

+Please complete the form below and return this sheet with a **voided check** to:

IPSSA, Inc.
PO Box 254645
Sacramento, CA 95865-4645

If you have questions, please contact IPSSA Member Services at 1-888-360-9505, ext. 1 or email memberservices@ipssa.com

Company Name:

IPSSA Member #

I (we) hereby authorize IPSSA Inc. to initiate debit entries and initiate, if necessary, credit entries and adjustments for entries made in error to my (our) checking account indicated below at the depository (Bank) named below to debit the same such account.

Bank Name (your financial institution)

Branch Address

City, State, Zip

Routing Number

Account Number

This authorization is to remain in full force and effect until IPSSA, Inc. has received written notification from me (or either of us) of its termination in such time and in such manner as to afford IPSSA, Inc. and Bank a reasonable opportunity to act on it.

Name (Primary name on your bank account)

Secondary name on account, if applicable

Signature of primary account name

Signature of secondary name, if applicable

Dated

Dated



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**Set up recurring dues payments by VISA, MasterCard, Discover or American Express
(Rev. 1/2022)**

With your authorization, IPSSA can automatically debit your credit card for your monthly dues owed to IPSSA.

+The debit will be made on the 10th of each month or on the first business day after the 10th if it is a holiday or weekend day.

+ If your card is declined, you will be subject to late fees after the 15th of the month.

+Please complete the form below and return it to:

IPSSA, Inc.
PO Box 254645
Sacramento, CA 95865-4645
Fax: 1-888-368-0432

If you have questions, please contact IPSSA Member Services at 1-888-360-9505, ext. 1 or email memberservices@ipssa.com

Company Name:

IPSSA Member #

I (we) hereby authorize IPSSA Inc. (by signature below) to charge the credit card below each month on a recurring basis for IPSSA membership dues. This authorization is to remain in full force and effect until IPSSA has received written notification of its termination in such time and in such manner as to afford reasonable opportunity to act on it.

Credit Card Type

VISA

MasterCard

Discover

AMEX

Card Number

Expiration Date (mm/yr)

Card Code

Name as it is printed on the credit card

Billing address (street)

City, State, Zip

Signature

Date