



MEMBERSHIP APPLICATION

APPLICANT INFORMATION

Name:

Email:

Home address:

City:

State:

ZIP Code:

Home:

Cell:

Work:

TYPE OF MEMBERSHIP (CIRCLE ONE)

Middle/High School	\$5	Family	\$50	Benefactor	\$1000
Student	\$15	Professional*	\$75	Other	
Senior (65+)	\$15	Sustaining	\$200		
Individual	\$35	Patron	\$500		

*PROFESSIONAL MEMBERS ONLY

Occupation:

Credentials:

Office Address:

City:

State:

ZIP Code:

Website:

Treatment Specialties:

Treatment Modalities: (Circle one) Individual Couples Group Family Medical Nutritional Other: _____

Treatment Setting: (Circle one) Inpatient Residential Outpatient School/College Counseling Other: _____

Populations Served:

How long in practice?

Region of practice: (Circle one) Northeast Northwest Central Southeast Southwest

Insurance providers accepted:

Other Information:

I would like my business information posted on the okeatingdisorders.org website

Initial here _____

PAYMENT OPTIONS (PLEASE MAIL FORM AND PAYMENT TO BELOW ADDRESS)

Amount: _____ CHECK (Check # _____) Amount: _____ CASH (Do not mail cash)

SIGNATURES

I attest that the above information recorded is true and correct to the best of my knowledge.

Print Name:

Date:

Signature:

Date: