



Please Print

Name: (include licenses/degrees)

Home Street Address

City, State, Zip

() Home Phone including area code

Email Address (required)

Employer

Occupation

Work Street Address

City, State, Zip

() Work Phone

Ext.

() Work Fax

Have there ever been any ethical, legal, or professional proceedings, ethical hearings, malpractice, etc brought against you?

Yes No (You must check one)

If yes, please explain:

By signing below, I do attest that the information provided on this application is true and correct to the best of my knowledge. I am aware that The International Associations of Eating Disorders Professionals Foundation does have the right to request additional information from me should it be needed and iaedp™ also reserves the right to refuse any application for membership.

Signature

Date

Annual Membership Dues

Individual Membership

\$195

Organizational Membership

\$1500

Full Time Student Member

\$75*

First Year Chapter Member

\$125

*Must have official documentation of semester hours.

Detach, complete, and return by fax or mail:

iaedp™ PO Box 1295 Pekin, IL 61555-1295 Fax: (800.800.8126)

Please Print All Information

Type of Credit Card: VISA MasterCard American Express Discover

Account Number:

Expires /

Name as it appears on card:

Billing Address: (include street, city, state and zip)

Total Membership Fees: \$ Chapter Joined

Signature

Date