providing education and certification
promoting effective treatment

iaedp

the international association of eating disorders professionals foundation

Please Print	*(Office Use Only) Membership #*

Name: (include licenses/degrees)

Home Street Address — City, State, Zip

( )

Home Phone including area code — Email Address

Employer — Occupation

Work Street Address — City, State, Zip

( ) Ext.________( )

Work Phone — Work Fax

Work Email Address

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 IAEDP 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*
Certification Manual $25
**Must have official documentation of semester*

Detach, complete, and return by fax or mail:

IAEDP
PO Box 1295
Pekin, IL 61555-1295
Fax: (309-346-2874)

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)

Calculate and Insert Total Here:

$________________________

Signature ***Date***