Please Print *(Office Use Only) Membership #*

____
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

( )______________________ Ext.__________ ( )______________
Work Phone 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
$100

**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***______________________
(if applicable)

______________________ ______________________
Signature ***Date***