Eating Disorder Task Force of Indiana

Membership Application Form

Name:____

Current Position:____

Mailing Address:____

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E-mail Address:____

Telephone: Home______________Work______________Fax______________

Discipline:____

Applicants for full membership:

1. A copy of your license, certificate, or highest degree
2. Original date of licensure: ___________________________________
3. Name and address of one reference who can speak to your knowledge and experience in the field of eating disorders.

Name:___________________________ Telephone number:_______________

Address:____

4. If you are a treatment provider, have you completed at least 50 hours of training/supervision in eating disorders? Yes____ No_____

   If you are a treatment provider, have you spent at least 100 hours of treating patients with eating disorders? Yes __ No __

If you are not a treatment provider, have you had at least 30 hours of professional activities related to eating disorders? Yes __ No __

Applicants for Associate Membership:

1. A copy of your resume

For all applicants:

Have you ever been subject to disciplinary action by a professional organization, hospital, or institution? Yes __ No __

If yes please explain:____

Signature____________________________________Date___________________

Email signed application with brief cover letter to edtfimembers@gmail.com