Eating Disorder Task Force of Indiana
Membership Application Form

Name:____
Current Position:____
Mailing Address:____
E-mail Address:____
Telephone: Home_____________Work_____________Fax_____________
Discipline:____

Applicants for full membership:

1. A copy of your license, certificate, or highest degree

2. Name and address of one reference who can speak to your knowledge and experience in the field of eating disorders.
   Name:_________________________ Telephone number:______________
   Address:____
3. 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__________________

Make your $30 check payable to Eating Disorder Task Force of Indiana and mail to:

Todd Davis, Selah House, 2541 N Shore Blvd Anderson, IN 46011