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 $20 check payable to Eating Disorder Task Force of Indiana and mail to:

Dr. Mary Rouse, Charis Center for Eating Disorders,
6640 Intech Blvd., Suite 195, Indianapolis, IN 46278