Membership Application

I am applying for membership as: ❑ Regular ❑ Affiliate ❑ Student ❑ New Professional ❑ Introductory ❑ Fellow

Name (First/Given) (Last/Family) Credentials

❑ Female ❑ Male

Organization

Address

City State/Province ZIP/Postal Code

Country

Phone (Business) Fax E-mail

Professional Information

Highest Degree: ______________________________

Discipline:

❑ Dietetics/Nutrition ❑ Nursing ❑ Psychology ❑ Exercise Physiology ❑ Counseling ❑ Primary Medicine
❑ Marriage/Family Therapy ❑ Psychiatry ❑ Social Work ❑ Physician/Pediatrician ❑ Epidemiology
❑ Other (specify) ______________________

Institutional Affiliation: ______________________________
Do you identify yourself as: ❑ Clinician ❑ Researcher ❑ Both ❑ Neither
If someone referred you to AED, please indicate his/her name ______________________________
List memberships in other professional organizations:
____

Are you a member of an AED sister organization? If so which one? ______________________________
Are you interested in learning about or joining a SIG? ❑ Yes ❑ No
For a complete listing and description of current SIGs, visit www.aedweb.org.

Practice Parameters *(check all that apply)*

I see: ❑ Children ❑ Adolescents ❑ Adults ❑ All ages ❑ Families
My practice is: ❑ Outpatient ❑ Inpatient/residential ❑ Residential ❑ Both ❑ Other (specify): ______________________

Payment Information *(Please see the AED dues chart to find the dues amount for your membership type and nation of residence.)*

Membership year is **January 1 through December 31.** Dues are billed on a calendar year, not anniversary. Dues are not prorated.
Journal subscribers will receive back issues for the months prior to the join date of that membership year.

Please see our website at *www.aedweb.org* for membership descriptions. Please see the 2010 Dues Table for the fee schedule.

Save now and avoid future dues increases. Yes! Sign me up for: ❑ 1 year ❑ 2 years ❑ 3 years
❑ Check *(make payable to the Academy for Eating Disorders in US funds)*
❑ VISA ❑ MasterCard ❑ American Express

Payment Enclosed: $______________________________

Card Number Expiration Date

Credit Card Billing Address (if different from above)

Signature

Mail or fax payment to:
Academy for Eating Disorders • 36841 Treasury Center • Chicago, IL 60694-6800 • Fax: 847/480-9282