



## Eating Disorder Task Force of Indiana 2010 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 checks payable to Eating Disorder Task Force of Indiana and mail to:

Valerie Staples, University Counseling Center, 3rd floor Saint Liam Hall, University of Notre Dame, Notre Dame, IN 46556