Eating Disorder Task Force of Indiana

Full Membership Application Form

Licensed clinicians of any kind

Demographic Information

Name:_____

Current Employer and Job Title:_____

Business Mailing Address:_____

_____

_____

Business E-mail Address:_____

Business Telephone: _____ Business Fax:_____

Discipline:_____

License Number: _____ Original date (year) of licensure: _____

**The above information will be published on the EDTFI website and be made public*

Documentation needed for full membership:

1. A copy of your license
2. Copy of CV/Resume
3. A brief cover letter highlighting background and interest in joining EDTFI

Professional Reference

Please provide the name and address of one reference who can speak to your knowledge and experience in the field of eating disorders.

Reference Name:_____ Reference Phone number_____

Reference Email: _____

Reference Job Title and Employer:_____

Eating Disorder Training History

1. Have you completed at least 50 hours training/supervision in eating disorders?
   Yes____ No_____

2. Have you spent at least 100 hours treating patients with eating disorders?
   Yes ____ No _____

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3. Have you had at least 30 hours of professional activities related to eating disorders?
   Yes ____ No _____
   If Yes, what activities: _____

_____

Disciplinary History:

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

If yes please explain:_____

_____

Applicant Signature:_____Date:_____

*Email the above documentation and this completed and signed application to membership@edtfi.org

Note: The EDTFI membership committee currently meets every 6 weeks to review applications.