



Application for Associate Membership

PERSONAL INFORMATION:

Title: Dr. Mr. Ms. Mrs.

Name in Full: First: _____ Last _____

Date of Birth: (dd/mm/yyyy) _____ Male: Female:

Work Address: _____

Work Telephone No: _____ Work Fax No.: _____

Home Address: _____

Home Telephone No: _____ Home Fax No.: _____

Email Address: _____

Please mail Members Package to my: HOME WORK

Newsletters and updates will be sent out by email. Hard copies will be mailed upon request only. Please notify **if** you are unable to receive correspondence by email.

LICENSING / CERTIFICATION

Associate Membership:

Date and Place Professional Degree / Training was received:

University: _____

Province / Country: _____

Date: (MM/DD/YEAR): _____

Degree: _____

Are you currently a member in good standing of your licensing body? Yes No

Are there currently any complaints lodged against you? Yes No

Please Attach the following documentation:

- Copy of your certification or license to practice

Names and addresses of two professional references who can substantiate criteria by which membership is being sought:

Reference One:

Name: _____

Address: _____

Telephone No.: _____ Email: _____

Reference Two:

Name: _____

Address: _____

Telephone No.: _____ Email: _____

PAYMENT OPTIONS:

Please make cheque or money order payable to the Canadian ADHD Resource Alliance (or CADDRA), or provide credit card information below.

Associate Membership Fees: \$150.00 + \$19.50 HST - \$169.50.

MasterCard

Visa

Cheque Enclosed

Card Number: _____ Expiry Date: _____

Name of Cardholder (as it appears on card): _____

Signature: _____ Date: _____

Declaration:

I understand that CADDRA will make inquiries about my professional training and practices, either from professional societies, individual references or any other individuals who may know my past or present professional activities, if such are deemed necessary. I also understand that CADDRA is not obligated to offer membership on the basis of this application.

I affirm that all the information in this application is true.

(Date) _____ **(Signature)** _____

Return to:

Canadian ADHD Resource Alliance (CADDRA)

Membership Department

3950 14th Avenue, Suite 604

Markham, ON L3R 0A9

tel: 416-637-8583

fax: 905-475-3232

***Please remember to submit copies of all documentation required.**