



Application Form

Contact Information:

Name: _____

Degree(s): _____ Title: _____

Current practice/Institution/Business: _____

Preferred mailing address: _____

City, State, Zip (Country if other than U.S.): _____

Business phone _____ Cell phone: _____ Email: _____

Fees

Initial Enrollment Fee **\$249**

Donation to ADAA _____

Total amount due \$ _____

Payment

Check (Make payable to ADAA) Visa MasterCard

Card number _____

Expires _____ Security code _____

Name on card _____

Signature _____

In signing below I verify that as an ADAA Clinical Fellow:

I am licensed to practice in state/specialty
Clinician license # _____ State _____

I have been in practice for a minimum of five years.

I have been an ADAA professional member for at least three years. (Exceptions may be made on a case-by-case basis)

I have proof of current malpractice insurance.

I will earn 24 hours of continuing education through ADAA activities within two years of registering for the program.

I will earn 12 hours of continuing education through ADAA activities every two years to maintain ADAA Clinical Fellow status. I

agree to allow ADAA to use my name and likeness in promotional materials for ADAA Clinical Fellows.

I have no ethical violations according to my state and professional code of conduct and I have maintained state licensing requirements.

Signature: _____

Date: _____

Send this completed application to:

ADAA | 8701 Georgia Avenue, Suite 412 | Silver Spring, MD 20910
lpatterson@adaa.org | Fax 240-485-1035 | Phone 240-485-1030