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 vspielman@adaa.org | Fax 240-485-1035 | Phone 240-485-1030