



Illinois Association for Behavioral Health

CORPORATE MEMBERSHIP APPLICATION

1. Main Contact

Name _____

Title _____

Company _____

Address _____
Street City State Zip

Phone () _____ Fax () _____

E-Mail Address _____

Website _____

Satellite Locations – Attach another sheet of paper if there is more than one Satellite location.

Address _____
Street City State Zip

Phone () _____

Briefly describe the services and/or products you provide to addiction and mental health services providers:

Please return this form with a check for \$5000 (annual dues) to:

IABH
c/o Pel Thomas
937 South Second Street
Springfield, Illinois 62704