AFFILIATE MEMBERSHIP APPLICATION

Main Contact

Name _____

Title _____

Company _____

Address _____
Street City State Zip

Phone _____ 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 providers:

Please return this form with your check for membership dues ($1,500) amount to:

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