



ALABAMA NETWORK FOR
EATING DISORDERS AWARENESS
giving direction ~ giving hope

ALNEDA TREATMENT PROVIDER APPLICATION

Personal Information

Name _____

Credentials _____

Agency _____

Work Address _____

Work Phone _____ Fax _____

Email _____

Professional Information

Graduate Degree _____

Licensed By _____

License # _____

Certified By _____

Certification # _____

Please send this along with a completed membership application and check
(payable to ALNEDA) to:

ALNEDA
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