MEMBERSHIP APPLICATION

(Please type or print)

Name__________________________________________

Address________________________________________

City________________________ State________ Zip_______

Business Phone (        )________________________ Fax (        )_____________
Home Phone(        )________________________ E-mail________________________

Education Level Current Employer________________

AA Nursing Full time
BSN Part time
MSN
Diploma
LPN Number of years CD experience_____

Age:  
20-29  30-39  40-49  50-59  60-69  Over 70

Areas of Practice

Inpatient Detox
Outpatient Detox
Methadone maintenance program
Research programs (Chemical Dependency)
Out Patient Chemical Dependency Program
Inpatient Chemical Dependency Rehabilitation program
Residential Chemical Dependency Program
Other

Would you like to be included in our speakers list? Yes  No

Fee $100.00 Check  Money Order  Make payable to MACDN

Credit Card type_________________________card #_________________________
Exp.date.______________Signature________________________Date__________

Send form with payment to:

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