CALIFORNIA ASSOCIATION OF ALCOHOLISM/DRUG ABUSE COUNSELORS
AGENCY MEMBERSHIP APPLICATION

Agency Name: ____

Contact Person: ____________________________Work Phone: (_____) _____________

Name of person to receive the individual full membership: ___________________________

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Home/Cell Phone: (___) _________________ E-mail:________________________________

Agency Address: ____

City: _____________________________________State: ________ Zip Code: ____________

Agency Membership Annual Dues are $230.00
Agency Membership includes all of the Agency Membership Benefits
Agency Membership includes one individual full membership with CAADAC and all of the Membership Benefits
Please note that all fees paid to CAADAC are non refundable

METHOD OF PAYMENT:

1. ____Check ____Money Order

Mail with fee to: **CAADAC**, 3400 Bradshaw Rd., Ste. #A-5, Sacramento, CA 95827

2. _____ Visa _____ MasterCard _____ American Express _____ Discover

Mail to address above or fax to: **CAADAC,** 916-368-9424

Card Number ____

Expiration Date ______________________ 3 or 4 digit Security Code on Back________________

Name as it appears on Card ____

Signature ____

Billing address for card ____

PLEASE ALLOW 4 WEEKS FOR DELIVERY