

CALIFORNIA ASSOCIATION OF ALCOHOLISM/DRUG COUNSELORS AGENCY MEMBERSHIP APPLICATION



Agency Name: _____

Contact: _____

Mailing Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Name Individual to receive individual full membership: _____

Home Phone: (____) _____ Work Phone: (____) _____

Fax: (____) _____

E-mail: _____

METHOD OF PAYMENT:

Agency Membership Annual Dues: \$230.00

Agency Membership includes: One individual full membership with CAADAC and all of the other benefits listed under the Agency Membership Benefits.

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: _____