

**CALIFORNIA ASSOCIATION OF ALCOHOLISM/DRUG COUNSELORS
AGENCY MEMBERSHIP APPLICATION**



Agency Name: _____

Individual Member: _____

Mailing Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____

Work Phone: (____) _____

Fax: (____) _____

E-mail: _____ Web Page address: _____

METHOD OF PAYMENT: (Agency Membership is \$200 and includes one individual membership.)

1. ____ Check ____ Money Order

Mail with fee to: CAADAC, 3400 Bradshaw Rd., Ste. A-5, Sacramento, CA 95827 or fax to 916.368.9424.

2. ____ Visa ____ MasterCard

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: _____