**Anxiety and Depression Association of America**

Professional Membership Application

Apply online at **www.adaa.org** or send this completed application to  
ADAA 8701 Georgia Ave., Suite 412 Silver Spring, MD 20910   
Fax 240-485-1035 | Phone 240-485-1030

**Contact information**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Degree(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current institution/business\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State/Province\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_Country\_\_\_\_\_\_­­\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Include in your online practice profile?  Yes  No

**Do you want your practice profile listed in the ADAA *Find a Therapist* online directory?**  Yes  No

**I am a** *(check all that apply)*  Clinician  Researcher  Researcher/Clinician

Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred mailing address *(if different from above)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My Practice Profile** (What you want clients to know about you and your practice)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Enhance my *Find a Therapist* listing:**

One additional practice address ($40)

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip/Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Link to your website ($55) published on your online listing.

URL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fees Payment**

Annual dues . . . . . . . . . . . . . . . . . . . . . . **$229**\_  Check

Additional office address ($40) . . . . . . . . \_\_\_\_\_  Visa  MasterCard

Website link ($55) . . . . . . . . . . . . . . . . . \_\_\_\_\_ Card number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Donation to ADAA . . . . . . . . . . . . . . . . . \_\_\_\_\_ Expires \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Security code \_\_\_\_\_\_\_\_\_

**Total amount due** . . . . . . . **$\_\_\_\_\_\_\_\_** Name on card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADAA Online Profile**

**Years in practice**

Fewer than 5  6 to 10  11 to 15

16 to 20  More than 20

**Payments**

Accept credit cards

Accept insurance

Medicare

Medicaid

Sliding scale

**Treatment** *(check all that apply)*

Adolescents/Teens

Adults

Children

Clinical trial enrollment

Couples

Families

Home visits

Inpatient

LGBT

Older adults (over 65)

Research only (no practice)

Online Treatment available

**Disorders treated** *(check all that apply)*

Agoraphobia

Anxiety/Fear

Anxiety and depression

Attention-deficit/hyperactivity disorder (ADHD)

Autism spectrum disorder

Bipolar disorder

Body dysmorphic disorder (BDD)

Body-focused repetitive behaviors

Depression

Eating disorders

Generalized anxiety disorder (GAD)

Hoarding

Obsessive-compulsive disorder (OCD)

Panic attacks/panic disorder

Phobias

Posttraumatic stress disorder (PTSD)

**Disorders treated, *continued***

Selective mutism disorder

Separation anxiety

Social anxiety disorder

Substance Abuse

Tourette and tic disorders

Trauma

Trichotillomania

**Practices** *(check all that apply)*

Acceptance and commitment therapy (ACT)

Breathing and relaxation techniques

Cognitive-behavioral therapy (CBT)

Dialectical behavioral therapy (DBT)  EMDR

Exposure therapy

Intensive exposure protocols

Interpersonal therapy (IPT)

Medication prescription

Medication referral

Mindfulness

**Licenses**

Clinician license #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please note: You may add anything not listed   
above to your online practice profile.*

I have enclosed a copy of my licensure or certification.

**Ethics statement***In signing below, I verify that I have no ethical violations according to my state and professional code of conduct and I have maintained state licensing requirements.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date