



MEMBERSHIP APPLICATION

**500 Montgomery Street Suite 400
Alexandria, VA 22314**

Phone: (703) 706-0560 Fax: (703) 706-0565 www.cadca.org

Please complete the application in full and return it to the above address or fax with credit card authorization or check or money order payable to CADCA.

MEMBER INFORMATION		
Name:	Title:	
Organization:		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	
Email:	Website:	

CADCA MEMBERSHIP CATEGORIES	
MEMBER TYPE	ANNUAL DUES (✓)
Sustaining · State Level Organizations (The Single State Authority for Alcohol, Tobacco, and Other Drugs) · National Organizations	<input type="checkbox"/> \$2,500
Special Interest Group Any departments or agencies within state or local governments, prevention/treatment centers, or other organizations interested in supporting substance abuse prevention programs and building safe, healthy, and drug-free communities.	<input type="checkbox"/> \$550
Community Coalition/Community Based Organization <i>(Please select the appropriate dues amount. Includes CADCA benefits for all your members.)</i> Your annual budget is: \$500,000 and above \$300,000-\$499,000 \$100,000-\$299,000 \$0-\$99,000	\$550 \$450 \$350 \$250
Prevention Professional Any individual who works in the substance abuse and prevention field, but does not belong to a specific organization.	\$250
Professional Student To qualify for the Professional Student Membership, you must provide proof of enrollment at the graduate level in an accredited higher learning institution. Applicable areas of study include Public Health, Health Care Sciences, Healthcare Administration, Health Education, Health services, Healthcare Management, Addiction Studies, Clinical Mental Health Counseling, School Counseling, Social Work, Nursing, Psychology, Human Services, and related programs. Upon enrollment, please email proof of enrollment to membership@cadca.org	\$100
Friend of CADCA Any individual with an interest in supporting substance abuse prevention programs and in building safe, healthy and drug-free communities.	\$50






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Please complete this form for all additional staff members.

PAYMENT INFORMATION	
<input type="checkbox"/> Check Enclosed	Check type of credit card: <input type="checkbox"/>  <input checked="" type="checkbox"/>  <input type="checkbox"/> 
Account Number:	Expiration Date:
Full name (as it appears on credit card):	
I authorize you to charge \$ _____ to my credit card.	
Signature:	

ADDITIONAL STAFF INFORMATION		
Name:	Title:	
Organization:		
Address:		
City:	State:	ZIP Code:
Phone:	Fax:	
Email:	Website:	

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Organization:		
Address:		
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