



## Eating Disorder Network of Maryland: Referral Treatment Team Application

Please print this application and provide all of the requested information.  
Then mail your completed application and check to EDN of Maryland:  
**744 Dulaney Valley Rd, Suite 9, Towson, MD 21204**

Name /Credentials: \_\_\_\_\_ License # (if applicable) \_\_\_\_\_

Agency/Organization (if self, leave blank): \_\_\_\_\_

Individual Team Member (\$75.00) \_\_\_\_\_ Small Business Team Member (\$175.00) \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Maryland County: \_\_\_\_\_

Email: \_\_\_\_\_

Webpage: \_\_\_\_\_

Special Populations Served: \_\_\_\_\_

### ***Contract Agreement***

All information provided on this application is true and correct to the best of my knowledge. I understand that this referral listing is property of **EDN of Maryland** and will remain a part of the online directory so long as the information is found to be truthful and the annual fee is paid promptly. Changes to this listing can be made via email to [ednmaryland@gmail.com](mailto:ednmaryland@gmail.com).

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

***Contract Valid: 11/15/2011-11/14/2012***

*To be completed by EDN Maryland:*

Date application received: \_\_\_\_\_ Start date of online listing: \_\_\_\_\_

Fee paid: \_\_\_\_\_ Check number: \_\_\_\_\_