



Eating Disorders Coalition Friends of the EDC Registration Form

Friends of the EDC: \$100

Contact Information:

E-mail Address: _____

First Name: _____ **Last name:** _____

Address : _____

Address (Line 2): _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

(optional) Company: _____

(optional) Title: _____

How did you first learn about the Eating Disorders Coalition?:

- A presentation or briefing by the EDC
- A story in the media (print broadcast or online)
- A treatment program for medical or mental health
- An email that I received
- Another nonprofit organization
- Internet search
- Word of mouth (friend, family member or coworker)
- Other

How would you best describe yourself?:

- Family member or friend of someone who has had an eating disorder
- Person who has or has had an eating disorder
- Member of US House or US Senate or staffer
- Treatment professional or administrator
- Researcher
- School employee (K-12)
- Student
- Other

Ideas, comments, or ways you want to be involved:

Payment Information:

Payment Type (Circle One): Credit Card / Check

Name on Card: _____

Credit Card #: _____

Credit Card Type: American Express / MasterCard / Visa

Expiration date: _____ / _____ **Security Code:** _____

Billing Address (if different): _____

Billing Address (Line 2): _____

City: _____ **State:** _____ **Zip:** _____

- YES**, I would like my name listed on the EDC website.
- NO**, I do not want my name listed on the EDC website.

Please send completed forms to:
manager@eatingdisorderscoalition.org

or

EDC
P.O. Box 96503-98807
Washington, D.C. 20090