



**Illinois Association for Behavioral Health**

**AFFILIATE MEMBERSHIP APPLICATION**

**1. Main Contact**

Name \_\_\_\_\_

Title \_\_\_\_\_

Company \_\_\_\_\_

Address \_\_\_\_\_

Street City State Zip

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Website \_\_\_\_\_

Satellite Locations – Attach another sheet of paper if there is more than one Satellite location.

Address \_\_\_\_\_

Street City State Zip

Phone ( ) \_\_\_\_\_

Briefly describe the services and/or products you provide to addiction and mental health services providers:

Please return this form with a check for \$1000 (annual dues) to:

**IABH**  
**c/o Pel Thomas**  
**937 South Second Street**  
**Springfield, Illinois 62704**