MEMBERSHIP FORM

I WISH TO BE A MEMBER OF THE INTERNATIONAL ASSOCIATION FOR WOMEN'S MENTAL HEALTH

Family Name_____ Gender: ❑ F ❑ M

First Name_____ Middle Name_____

Affiliation / Institution_____

Full Mailing Address _____

_____

City_____ Country_____ Postal Code_____

Telephone_____ Fax Number_____

E-mail_____

Your Profession:

❑ Psychiatrist ❑ Gynecologist ❑ Other MD ❑ Psychologist ❑ Nurse ❑ Social Worker
❑ Policy Maker ❑ Researcher ❑ Academic ❑ Other _____

Area of Interest / Activity / Research:

❑ Women & Psychiatric Disorders ❑ Treatment Issues for Women with Mental Illness
❑ Etiology & Prevention of Mental Illness ❑ Psychological Aspects of Medical Illness
❑ Political & Sociocultural Issues ❑ Violence ❑ Women's Mental Health in Special Populations
❑ Reproduction & Women's Mental Health ❑ Infertility ❑ Pregnancy ❑ Pregnancy Termination
❑ Postpartum ❑ Menopause ❑ Sexuality ❑ Medical - Legal
❑ Other _____

Dues – *payable on an Annual Basis and renewable on September 1, 2016.*

❑ $150 USD – Category A Country ❑ $75 USD – Category B Country - *See list of countries at www.iawmh.org*
www.iawmh.org to sign up on line.

Payment by Visa, MasterCard, or American Express. **Credit card payments may be faxed to (301) 983-6288.**

❑ Master Card ❑ Visa ❑ AMEX Credit Card Number: _____
Billing Address of Cardholder:_____
_____
Last 3 or 4 Digits on the Back of the Credit Card: _____Exp. Date:_____ /_____ /_____
Amount Authorized to Charge on Credit Card: $_____
Signature:_____ Name on Card: _____
The Above Signature Hereby Authorizes This Transaction

Wire transfer information available upon request – email to info@iawmh.org

PLEASE RETURN THIS COMPLETED FORM WITH CREDIT CARD INFO OR WITH CHECK TO:

IAWMH • 8213 Lakenheath Way • Potomac, Maryland 20854 USA

OR FAX TO: (301) 983-6288 OR EMAIL TO: INFO@IAWMH.ORG