



## **MEMBERSHIP FORM**

**I WISH TO BE A MEMBER OF THE**

**INTERNATIONAL ASSOCIATION FOR WOMEN'S MENTAL HEALTH**

Family Name \_\_\_\_\_

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Affiliation / Institution \_\_\_\_\_

Full Mailing Address \_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ Country \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone \_\_\_\_\_ Fax Number \_\_\_\_\_

E-mail \_\_\_\_\_

Professional Position \_\_\_\_\_

Academic Degree \_\_\_\_\_ Gender:  F  M

Area of Interest / Activity / Research \_\_\_\_\_

\_\_\_\_\_

**I WISH TO SUBSCRIBE TO THE**

**ARCHIVES OF WOMEN'S MENTAL HEALTH JOURNAL:** Yes  No

Activities in which I would like to be involved / initiate: \_\_\_\_\_

\_\_\_\_\_

Suggestions: \_\_\_\_\_

\_\_\_\_\_

**PLEASE RETURN THIS COMPLETED FORM TO:**

IAWMH • 8213 Lakenheath Way • Potomac, Maryland 20854 USA

OR FAX TO: (301) 983-6288