



**MEMBERSHIP APPLICATION Community
Community Anti-Drug Coalitions of America**




500 Montgomery Street Suite 400 Alexandria, VA 22314

Phone: (703) 706-0560 Fax: (703) 706-0565 www.cadca.org

Please complete the application in full and return it to the above address or fax with credit card authorization or check or money order payable to CADCA.

MEMBER INFORMATION		
Name:	Title:	
Organization:		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	
Email:	Website:	
How did you hear about us?		DFC Grantee?

CADCA MEMBERSHIP CATEGORIES	
MEMBER TYPE	ANNUAL DUES (✓)
Sustaining · State Level Organizations (The Single State Authority for Alcohol, Tobacco, and Other Drugs) · National Organizations	<input type="checkbox"/> \$2,500
Special Interest Group Any departments or agencies within state or local governments, prevention/treatment centers, or other organizations interested in supporting substance abuse prevention programs and building safe, healthy, and drug-free communities.	<input type="checkbox"/> \$500
Community Coalition/Community Based Organization <i>(Please select the appropriate dues amount. Includes CADCA benefits for all your members.)</i> Your annual budget is: \$500,000 and above \$300,000-\$499,000 \$100,000-\$299,000 \$0-\$99,000	<input type="checkbox"/> \$500 <input type="checkbox"/> \$400 <input type="checkbox"/> \$300 <input type="checkbox"/> \$200
Prevention Professional Any individual who works in the substance abuse and prevention field, but does not belong to a specific organization.	<input type="checkbox"/> \$200
Friend of CADCA Any individual with an interest in supporting substance abuse prevention programs and in building safe, healthy and drug-free communities.	<input type="checkbox"/> \$50

PAYMENT INFORMATION	
<input type="checkbox"/> Check Enclosed	Check type of credit card: <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/> 
Account Number:	Expiration Date:
Full name (as it appears on credit card):	
I authorize you to charge \$ _____ to my credit card.	
Signature:	



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Please complete this form for all additional staff members.

ADDITIONAL STAFF INFORMATION		
Name:	Title:	
Organization:		
Address:		
City:	State:	ZIP Code:
Phone:	Fax:	
Email:	Website:	

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