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, 2014.*

❑ $150 USD – Category A Country ❑ $75 USD – Category B Country - *See list of countries*

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

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