



Anorexie et boulimie Québec

Reference Application Form

Family name, Given name: _____

Telephone numbers:

- Cell: (____) – ____ - _____
- Home: (____) – ____ - _____
- Work: (____) – ____ - _____

E-mail address: _____

Profession:

- | | |
|--|--|
| <input type="radio"/> Nutritionist/dietician | <input type="radio"/> Psychoeducator |
| <input type="radio"/> Psychologist | <input type="radio"/> Occupational therapist |
| <input type="radio"/> Sexologist | <input type="radio"/> Other, specify: |
| <input type="radio"/> Social worker | _____ |

Name of professional order: _____

Permit number: _____

Type of practice and number of years experience in this type of practice:

- Private practice: ____ years and ____ months
- Public practice: ____ years and ____ months

Please note that requests will be evaluated every three months and that a phone call will be made in order to validate your information. *Along with this form, please attach an updated curriculum vitae as well as copies of attestations serving as proof of your specialization.*

Please send this document to ANEB by e-mail at info@anebquebec.com

Thank you!

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