RECOMMENDATION FORM
MEDA'S PREFERRED TREATMENT PROVIDER NETWORK

Thank you for filling out this brief recommendation for the Multi-Service Eating Disorders Association's Preferred Treatment Provider Network. MEDA is a non-profit organization dedicated to the education and treatment of eating disorders. Please indicate if you would recommend this applicant as a professional with experience in the field of eating disorders.

Your Name: ____

Address: ____

Email Address: ____

Applicant's Name: ____

Briefly state how long and in what capacity you have known this applicant:

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Please Choose One:

YES ☐ **NO** ☐: I am confident this individual has experience treating Eating Disorders.

YES ☐ **NO** ☐: I work in the field of eating disorders.

YES ☐ **NO** ☐: I am currently a member of MEDA's Preferred Treatment Provider Network.

Please Check One:

☐ I would recommend this individual as a Preferred Provider with MEDA.

☐ I have reservations about recommending this person.

Any further comments about this applicant:

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Signature: __________________________________ **Date:** ________________

Please return to: MEDA, 288 Walnut Street, Suite 130, Newton, MA 02460,
Email: info@medainc.org, or fax to 617.558.1771.