DBSA

Depression and Bipolar Support Alliance

Central Florida Chapter

Professional Advisor Information Form

Advisor Name, including credential(s):_____

Mailing Address: _____

City/State/Zip: _____

Telephone: _____ **Fax:** _____

Email: _____

I am willing to provide the following services to the chapter:

Select all that apply

- **Speak at educational meetings**
- **Consult with group leadership**
- **Refer patients to group**
- **Write/share articles for online publication**
- **Promote groups to professionals and the public**
- **Other (please describe):** _____

I am a licensed health care professional providing mental health services. I am supportive of the concept of self-help and peer-led support. I am well-versed in mood disorders, their causes and treatments. I am committed to the DBSA mission.

Advisor's signature/Date: _____

We want to recognize your support. Please provide us with a bio for the website.