

APPLICATION FOR MEMBERSHIP IN NDPhA

JANUARY 1—DECEMBER 31, 2010

Full Name: _____

Home Address: _____

City, St, Zip: _____

Home Ph: _____

Business Name: _____

Business Address: _____

Business Ph: _____

Fax: _____

City, St, Zip: _____

Prefer Mail Go To: Business Home

Email: _____

Would you like to receive email updates from NDPhA?

Yes No

Legislative District _____

ND License # _____ Year Graduated _____

Pharmacy School _____

Practice Setting

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Chain | <input type="checkbox"/> Manufacturer/Distributor |
| <input type="checkbox"/> Educator | <input type="checkbox"/> Non-Pharmacy |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Other |
| <input type="checkbox"/> Independent | |
| <input type="checkbox"/> Owner | |
| <input type="checkbox"/> Employee | |

Academies

Select one:

- Community Practice Academy (CPA)

I am interested in an academy for:

- Health-system Practice Academy (HPA) *this academy has been proposed to be added during the 125th Annual Convention in 2010*
- Long-term Care/Consultant
- Nuclear
- Compounding
- Student
- Other _____

Membership Categories

- Active Member (ND Licensed Pharmacists) \$100
- Corporate Member (Having a business interest in Pharmacy) \$750
- Associate Member (Spouse member, Out-of-State Pharmacist, Retired/Inactive) \$50
- Student Member Free of Charge

Optional Association Support

- Contribution to NDPhA Political Action Committee (PAC) (**Cannot be Corporate Checks**)
Amount _____
- Contribution to the Pharmacy Advancement Corporation (PhAC) NDSU Scholarship Fund (**These funds are used entirely to provide scholarships to NDSU College of Pharmacy Students. Personal or Corporate Checks are accepted.**)
Amount _____

Payment

Mail or Fax to:
NDPhA
1641 Capitol Way
Bismarck ND 58501-2195
Fax: 701-258-9312

- Check Enclosed Amount _____
- Charge my card this year only
- Automatically renew my membership annually by charging my card**

Name on Card: _____

Type (check one): Visa MasterCard

Credit Card # _____

Expiration Date _____ CVV _____
(3 digit code on the back of card)

PLEASE MAKE A COPY FOR YOUR RECORDS AND MAIL OR FAX TO:
NDPhA, MEMBERSHIP BENEFITS, 1641 CAPITOL WAY, BISMARCK ND 58501-2195 FAX: 701-258-9312