IPhA Membership Application

Home

First: _____ MI: __ Last: _____

Credentials: _____ (Ex: RPh, BA, PhD)

NABP ID: _____ DOB: MMDD

Street: _____

City: _____

State: _____ Zip + 4: _____ - _____

Phone: (_____) _____ - _____

Fax: (_____) _____ - _____

Email: _____

Business

Business Name: _____

Title/Position: _____

Street: _____

City: _____

State: _____ Zip + 4: _____ - _____

Phone: (_____) _____ - _____

Fax: (_____) _____ - _____

Email: _____

Who can we thank for referring you to IPhA:

_____

Please indicate your preferences for receiving IPhA communications

Postal Mail: ❍ Home ❍ Business

Email: ❍ Home ❍ Business

Fax: ❍ Home ❍ Business

IPhA Membership Type

- ☐ Regular Pharmacist Member $275.00
- ☐ Associate Member *(non-pharmacist)* $275.00
- ☐ Joint Member *(spouse of regular member)* $137.50
- ☐ New Pharmacist Practitioner 1 *(within 1 year of graduation)* $55.00
- ☐ New Pharmacist Practitioner 2 *(within 2 years of graduation)* $110.00
- ☐ New Pharmacist Practitioner 3 *(within 3 years of graduation)* $165.00
- ☐ New Pharmacist Practitioner 4 *(within 4 years of graduation)* $220.00
- ☐ Out-of-State Pharmacist Member $110.00
- ☐ Retired Pharmacist Member $110.00
- ☐ Academic Pharmacist Member $137.50
- ☐ Student $20.00
- ☐ Technician Member $40.00

Total Due: $ _____

What piqued your interest in becoming a member?

- ☐ Received a Renewal Notice
- ☐ An IPhA *Certificate Program*
- ☐ IPhA Website (*www.ipha.org*)
- ☐ Receiving the *Illinois Pharmacist* publication
- ☐ Friend/colleague referral
- ☐ IPhA presentation at a *Local Association Meeting*
- ☐ IPhA presentation at my *College of Pharmacy*
- ☐ Following IPhA via *Facebook/Twitter*
- ☐ Annual Meeting/CE Program

What is your primary practice setting?

☐ Chain	☐ Compounding	☐ Hospital/Health System	☐ Pharmacological	☐ Technician
☐ Clinical	☐ Government	☐ Independent	☐ Retired	☐ University
☐ Community	☐ Home Health Care	☐ Long Term Care	☐ Student	☐ Other: _____

Payment Method

☐ Check (Payable to IPhA)

☐ Credit Card: AMEX, MasterCard, Visa, Discover

Acct #: _____

Exp. Date: ____ / ____ / _____

Signature: _____

Qualifications

Graduation Date: ____ / ____ / _____

College/University: _____

Degree: _____

License #: _____ State: _____

Fax/Mail To: Illinois Pharmacists Association
204 West Cook St. | Springfield, Illinois 62704-2526
Phone: (217) 522-7300 | **Fax:** (217) 522-7349