

NORTH DAKOTA SOCIETY OF HEALTH-SYSTEM PHARMACISTS

MEMBERSHIP APPLICATION

NEW MEMBER PROFILE		
Last Name:	First Name:	M.I.
Title/Position:	Business/School Name:	
Business/School Address:		
City:	State:	ZIP Code:
Business Phone:	Business Fax:	
Home Address:		
City:	State:	ZIP Code:
Home Phone:	Home Fax:	
Preferred Mailing Address: <input type="checkbox"/> Home <input type="checkbox"/> Business/School		Preferred E-mail:

SELECT MEMBERSHIP (CHECK BOX THAT APPLIES)
--

- Pharmacist (\$75)

- New Practitioner (Pharmacist for less than 5 years) (\$50)

- Associate (\$30)

- Technician (\$30)

SELECT PAYMENT OPTION (CHECK BOX THAT APPLIES)
--

- CASH**
 CHECK

*Make all checks payable to: NDSHP
 Mail form and payment to: NDSHP c/o Megan Magle 5459 48th Ave S, Fargo, ND 58104

SIGNATURE

I authorize the verification of the information provided on this form to the best of my knowledge.

Signature of applicant: _____

Date: _____

