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: ❑ Home ❑ Business/School	Preferred E-mail:		

SELECT MEMBERSHIP (CHECK BOX THAT APPLIES)

- ☐ Pharmacist ($75)
- ☐ New Practitioner (Pharmacist for less than 5 years) ($50)
- ☐ Resident ($40)
- ☐ Associate ($30)
- ☐ Technician ($30)
- ☐ Student ($30)

SELECT PAYMENT OPTION (CHECK BOX THAT APPLIES)

❑ CASH **❑ CHECK**

*Make all checks payable to: NDSHP
Mail form and payment to: NDSHP c/o Gabby Anderson, 5248 10th St W, West Fargo, ND 58078

SIGNATURE

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

Signature of applicant: _____ Date: _____