mississippi Pharmacists Association

MEMBERSHIP FORM

Your membership matters to pharmacy in Mississippi

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Name:

____
LAST FIRST INITIAL

Mailing address:

____
STREET ADDRESS APT/SUITE

____
CITY STATE ZIP

Primary phone: (__________) __________ - ____________

Email: ____

Birthday: _____ /_____ /__________

Area of Profession:

☐ Academia ☐ Chain ☐ Independent

☐ Clinical/Health System ☐ Technician

☐ Consultant ☐ Industry ☐ Student

Optional Information

Employer: ____

Employer City/State: ________________________________

Work phone: (__________) __________ - ____________

Work Email: ____

Graduate of: ____________________ Graduation Year:

Today's date: _____ /_____ /________

Dues and Contributions:

☐ Student	$0
☐ Pharmacist – first year of practice	$0/first year
☐ Pharmacist	$150/year
☐ Pharmacy Technician	$25/year
☐ Joint Pharmacist (husband/wife)	$200/year
☐ Pharmacist – retired and over 65	$75/year
☐ Non-pharmacist/Associate	$100/year

Other:

☐ Mississippi Pharm-PAC $20 / $50 / $100

Payment Options:

☐ Enclosed is my check in the amount of $__________

☐ I want to pay my dues in full. Please bill my credit card below for $__________

☐ MasterCard ☐ Visa ☐ Amer. Express ☐ Discover

Card # ____

Exp. Date: _____ /_____ Security code: ___________

Please mail completed form to:

Mississippi Pharmacists Association
PO Box 16861
Jackson, MS 39236

I'd like to receive the quarterly journal:

☐ Electronically (e-Journal)

☐ Printed Copy by Mail

Thank you

for your support of MPhA

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