

MEMBERSHIP APPLICATION



FOUR WAYS TO JOIN

Online: www.ashp.org/join
Phone: 866-279-0681
Mail: ASHP Payment Center
PO Box 38069
Baltimore, MD 21297-8069

ASHP Membership Categories

Please choose one:

☐ Active Full Member \$365

For pharmacists who are licensed to practice in the United States and its Territories.

☐ New Practitioner

Resident or 1st Year New Graduate
\$94
2nd Year Post-graduate, Non-resident
\$188

Student*

☐ P1 Year - \$0

☐ P2-P4 Year - \$58

(Required: Please fill in Month/Year)

Graduation Date: _____

For individuals enrolled in a full-time undergraduate or graduate pharmacy program in an accredited U.S. college of pharmacy.

☐ TPTS Technician* \$58

Membership to The Pharmacy Technician Society (TPTS), with dual technician membership to ASHP. Includes subscription to AJHP and PharmacyTechCE.org.

☐ Retired \$188

For previous Active Full Members age 65 and older.

☐ International Associate* \$365

For pharmacists and non-pharmacists interested in pharmacy who reside outside the United States.

☐ Supporting Associate* \$365

For non-pharmacists who support the mission of ASHP.

☐ Joint Membership/Spouse

\$553 (\$365 + \$188)

One spouse pays full member dues, the other pays a reduced rate.

*Non-voting membership categories.

NEW MEMBER PROFILE

Last Name _____ First Name _____ M.I. _____

Title/Position _____

Business/School Name _____

Business/School Address _____

City/State/Zip/Province/Country _____

Business Phone _____

Home Address _____

City/State/Zip/Province/Country _____

Home Phone _____ Graduation Date (mm/yyyy) _____

Preferred Mailing Address _____

Preferred Email Address _____

Providing your email address allows you to receive timely updates on ASHP and pharmacy-related news and information.

ASHP SECTION(S)

Section membership is included **at no additional charge** to all members. You may join as many Sections as you wish, with full access to the specialized news, information, and services of each. If you choose more than one section, please indicate your preferred Primary Section in the space provided. In your Primary Section, you'll enjoy voting privileges for electing Section leadership and other matters concerning elected positions.

SECTION(S) I WISH TO JOIN	MY PRIMARY SECTION	
<input type="checkbox"/>	<input type="checkbox"/>	Section of Ambulatory Care Practitioners
<input type="checkbox"/>	<input type="checkbox"/>	Section of Clinical Specialists and Scientists
<input type="checkbox"/>	<input type="checkbox"/>	Section of Community Pharmacy Practitioners
<input type="checkbox"/>	<input type="checkbox"/>	Section of Digital and Telehealth Practitioners
<input type="checkbox"/>	<input type="checkbox"/>	Section of Inpatient Care Practitioners
<input type="checkbox"/>	<input type="checkbox"/>	Section of Pharmacy Educators
<input type="checkbox"/>	<input type="checkbox"/>	Section of Pharmacy Informatics and Technology
<input type="checkbox"/>	<input type="checkbox"/>	Section of Pharmacy Practice Leaders
<input type="checkbox"/>	<input type="checkbox"/>	Section of Specialty Pharmacy Practitioners

Pay dues on a monthly basis with a credit or debit card. You will be charged monthly for 1/12 of the membership fee. To participate in automatic monthly billing provide your credit or debit card number and agree to the terms below.

Method of Payment: (Please choose one) ☐ Annual Payment ☐ Monthly Payment*

All payments must be drawn on a U.S. bank in **U.S. dollars** only. Make all checks payable to ASHP.

ASHP Member Total \$ _____

TOTAL PAYMENT \$ _____

☐ Check enclosed for \$ _____ ☐ U.S. Purchase Order attached. Please issue an invoice.

☐ Charge to my: ☐ VISA ☐ MasterCard ☐ Discover ☐ American Express

Account # _____ Expiration Date _____ Signature (Required) _____

By signing below, I authorize ASHP to charge my credit/debit card as indicated for my full membership dues payment. If monthly billing is selected, my credit card will be charged one twelfth (1/12) the annual dues fee each month by ASHP until final payment is received. Per ASHP's membership terms and conditions, this authorization to charge my credit card will continue until I e-mail ASHP, custserv@ashp.org to discontinue my enrollment at which time I understand any remaining balance will be due in full.

Signature (Required) _____ Print Name _____

ASHP strongly encourages membership in an ASHP state affiliate organization. For more information on state affiliate nearest you, visit www.ashp.org/StateAffiliates.

A portion of the ASHP dues is not deductible as an ordinary and necessary business expense to the extent that ASHP engages in certain lobbying activities. For U.S. tax returns, the non-deductible portion of ASHP dues for 2025 is 19%. Payments to ASHP are not deductible as charitable contributors for federal income tax purposes. However, they may be deductible under other provisions of the Internal Revenue Code. ©2025 American Society of Health-System Pharmacists®. Prices subject to change.