

Membership Application

DATE



THREE WAYS TO JOIN!

- Online** www.ashp.org
Phone 866-279-0681
Mail ASHP Payment Center
 P.O. Box 17693
 Baltimore, MD 21297

Join ASHP online and save 5%!
 Enter discount code "SAVE 5"

ASHP Membership Categories

Please choose one.

- Active Full Member (A) \$240**
 For pharmacists who are licensed to practice in the United States and its Territories.
- Supporting Associate* (SA) \$240**
 For non-pharmacists who support the mission of ASHP.
- International Associate* (IA) \$240**
 For pharmacists and non-pharmacists interested in pharmacy who reside outside the United States and its Territories and are not U.S. citizens. Airmail service outside the U.S. and Canada is available for an additional \$182 per membership year.
- Joint Member/Spouse (J) \$375 (\$240 + \$135)**
 One spouse pays full member dues; the other pays a reduced rate.
- Technician w/AJHP®* (TJ) \$185**
 For individuals involved in pharmacy support roles. Includes an AJHP® subscription.
- Technician* (T) \$75**
 For individuals involved in pharmacy support roles.
- Retired (R) \$85**
 For previous Active Full Members age 65 and older.

Graduation date required for any box checked below.

- Student(s) (S)* \$38**
 Graduation Date: _____
 For individuals enrolled in a full-time undergraduate or graduate pharmacy program in an accredited U.S. college of pharmacy.
- For New Practitioners in the 1st through 5th year after graduation, please check box below:*
- New Practitioner, 1st yr. (G1) \$85**
 Graduation Date: _____
- New Practitioner, 2nd yr. (G2) \$153**
 Graduation Date: _____
- New Practitioner, 3rd yr. (G3) \$199**
 Graduation Date: _____
- New Practitioner, 4th yr. (G4) \$240**
 Graduation Date: _____
- New Practitioner, 5th yr. (G5) \$240**
 Graduation Date: _____

*Non-voting membership categories.

NEW MEMBER PROFILE

Please print or attach your business card.

Last Name _____ First Name _____ M.I. _____
 Title/Position _____
 Business/School Name _____
 Business/School Address _____
 City/State/Province/ZIP/Country _____
 Business Phone _____ Business Fax _____
 Home Address _____
 City/State/Province/ZIP/Country _____
 Home Phone _____ Home Fax _____
 Preferred Mailing Address Home Business/School _____
 Preferred E-mail Address _____
 Preferred State for House of Delegates elections, if different than preferred mailing address

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 I WISH TO JOIN	MY PRIMARY SECTION
<input type="checkbox"/>	<input type="checkbox"/> Section of Clinical Specialists and Scientists SM
<input type="checkbox"/>	<input type="checkbox"/> Section of Home, Ambulatory, and Chronic Care Practitioners SM
<input type="checkbox"/>	<input type="checkbox"/> Section of Inpatient Care Practitioners SM
<input type="checkbox"/>	<input type="checkbox"/> Section of Pharmacy Practice Managers SM
<input type="checkbox"/>	<input type="checkbox"/> Section of Pharmacy Informatics and Technology SM

PAYMENT OPTIONS

Pay dues on a monthly basis with a credit or debit card. You will be charged monthly for 1/12 of the membership fee. If your membership cycle is more than 12 months, your dues will be divided by the number of months in your cycle beginning the month you join. 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 Membership Total	\$ _____
Airmail Service (Optional for international associates only—add \$182)	\$ _____
TOTAL PAYMENT	\$ _____

- Check is enclosed for \$ _____
 U.S. Purchase Order # _____ attached; Please issue an invoice.
 Charge to my: VISA MasterCard Discover American Express
 Account # _____ Exp. Date _____

Signature (required) _____

* **TERMS FOR MONTHLY PAYMENT:** I authorize ASHP to charge my credit/debit card as indicated for my membership dues payment. For monthly billing, my credit card will be charged one twelfth (1/12) the annual dues fee each month by ASHP. This authorization to charge my credit card will continue until I e-mail ASHP, custserv@ashp.org, to discontinue.

Signature (required) _____ Print Name _____

Annual active membership dues are \$240, of which \$139 is for a subscription to AJHP®. 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 2009 is 35%. Payments to ASHP are not deductible as charitable contributions for federal income tax purposes. However, they may be deductible under other provisions of the Internal Revenue Code. © 2009 American Society of Health-System Pharmacists®. **Prices Subject to Change.**

ASHP strongly encourages membership in ASHP's affiliates. For more information on the affiliate nearest you, visit us online at www.ashp.org, or call 301-664-8644.