

# MEMBERSHIP APPLICATION



## FOUR WAYS TO JOIN

Online: [www.ashp.org/join](http://www.ashp.org/join)  
Phone: 866-279-0681  
Fax: 301-657-1251  
Mail: ASHP Payment Center  
PO Box 38061  
Baltimore, MD 21297-8061

## ASHP Membership Categories

Please choose one:

**Active Full Member**

**\$335 or less than \$28 a month**

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

**New Practitioner**

Resident or 1st Year New Graduate

**\$84, or \$7 a month**

2nd Year Post-graduate, Non-resident

**\$168, or \$14 a month**

**Student\***

**1 Year - \$54 or less than \$5 a month**

**2 Years - \$95 (Save \$13)**

**3 Years - \$140 (Save \$22)**

**(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.

**Technician\***

**\$54 or less than \$5 a month**

For individuals involved in pharmacy support roles. Includes subscriptions to AJHP and PharmacyTechCE.org.

**Retired**

**\$168, or \$14 a month**

For previous Active Full Members age 65 and older.

**International Associate\***

**\$335 or less than \$28 a month**

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

**Supporting Associate\***

**\$335 or less than \$28 a month**

For non-pharmacists who support the mission of ASHP.

**Joint Membership/Spouse**

**\$503 (\$335 + \$168)**

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 \_\_\_\_\_

Preferred state for House of Delegates election

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

What race or ethnicity best describes you?  American Indian or Alaska Native  Asian

Black or African American  Hispanic or Latino  Native Hawaiian or other Pacific Islander

White  Two or More Races  Prefer Not to Answer

What is your gender?  Female  Male  Nonbinary  Gender non-conforming

Prefer Not to Answer

## 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 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](mailto: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](http://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 2021 is 21%. 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. ©2021 American Society of Health-System Pharmacists®. Prices subject to change.*