Pennsylvania Pharmacists Association

## Health System Pharmacist-Corporate Membership Application- ACPA/BMPA/LVPA

PPA is extending a group discount to individual hospital locations to allow for multiple pharmacist (and pharmacy technician) memberships. Please complete the following application to activate your membership.

**Health System Corporate Membership: $570**

This fee includes membership for your Director of Pharmacy and two staff pharmacists, or for three of your staff pharmacists, at the same location/hospital. Each location is handled separately.

***After the initial $570 payment, additional memberships may be purchased as follows:***

- $165 for any additional staff pharmacist (above the three) at same location
- $35 for any pharmacy technician at same location

## Hospital/Health System Name: _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Phone**: _____ **Fax:** _____ **Website:**_____

## Individual Pharmacist #1

**Name:** _____ **Suffix:** _____
First M.I. Last (Sr., Jr., III, etc.)

**Title:** _____**Nickname:** _____ **Sex:** [ ] Female [ ] Male

**Preferred Salutation,** (*check one*): [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Miss [ ] Dr. **Date of Birth**:_____

**Name of Spouse:** _____

**Home Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**County:** _____ **Home Phone**: _____ **Home Fax:** _____

**Home E-Mail Address:** _____ **Work E-Mail Address:** _____

**Preferred Mailing Address:** [ ] Home [ ] Work **Preferred E-Mail:** [ ] Home [ ] Work

By providing the above fax number(s) and email addresses, I hereby am providing my informed and written consent to receive by fax and/or email any and all communications from the Pennsylvania Pharmacists Association and any of its subsidiary and affiliated organizations and entities. I understand that PPA does not share my fax numbers, home phone, or any email addresses with any other organization or business and only provides mailing addresses pending review and approval of intended mailings.

**Signature:** _____ **Date:** _____

**Are you a licensed pharmacist?** [ ] Yes [ ] No **Pennsylvania License Number:** _____
**Other States in which you hold pharmacy licenses:** (List all using state abbreviations): _____
**Pharmacy Graduate:** [ ] RPh. [ ] PharmD **Year:** _____ **College:** _____
**Other advanced Degrees held:** _____

Please Note any certificates/certifications in Healthcare/Pharmacy you have received:
(e.g. NIPCO, NISPC, and others)

_____

## Individual Pharmacist #2

**Name:** _____ **Suffix:** _____
First M.I. Last (Sr., Jr., III, etc.)

**Title:** _____ **Nickname:** _____ **Sex:** [ ] Female [ ] Male

**Preferred Salutation,** (*check one*): [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Miss [ ] Dr. **Date of Birth**:_____

**Name of Spouse:** _____

**Home Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**County:** _____ **Home Phone**: _____ **Home Fax:** _____

**Home E-Mail Address:** _____ **Work E-Mail Address:** _____

**Preferred Mailing Address:** [ ] Home [ ] Work **Preferred E-Mail:** [ ] Home [ ] Work

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**Other States in which you hold pharmacy licenses:** (List all using state abbreviations): _____
**Pharmacy Graduate:** [ ] RPh. [ ] PharmD **Year:** _____ **College:** _____
**Other advanced Degrees held:** _____

Please Note any certificates/certifications in Healthcare/Pharmacy you have received:
(e.g. NIPCO, NISPC, and others)

_____

## Individual Pharmacist #3

**Name:** _____ **Suffix:** _____
First M.I. Last (Sr., Jr., III, etc.)

**Title:** _____ **Nickname:** _____ **Sex:** [ ] Female [ ] Male

**Preferred Salutation,** (*check one*): [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Miss [ ] Dr. **Date of Birth**:_____

**Name of Spouse:** _____

**Home Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**County:** _____ **Home Phone**: _____ **Home Fax:** _____

**Home E-Mail Address:** _____ **Work E-Mail Address:** _____

**Preferred Mailing Address:** [ ] Home [ ] Work **Preferred E-Mail:** [ ] Home [ ] Work

By providing the above fax number(s) and email addresses, I hereby am providing my informed and written consent to receive by fax and/or email any and all communications from the Pennsylvania Pharmacists Association and any of its subsidiary and affiliated organizations and entities. I understand that PPA does not share my fax numbers, home phone, or any email addresses with any other organization or business and only provides mailing addresses pending review and approval of intended mailings.

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**Other States in which you hold pharmacy licenses:** (List all using state abbreviations): _____
**Pharmacy Graduate:** [ ] RPh. [ ] PharmD **Year:** _____ **College:** _____

**Other advanced Degrees held:** _____

Please Note any certificates/certifications in Healthcare/Pharmacy you have received:
(e.g. NIPCO, NISPC, and others)

_____

**Please copy the page above for any additional pharmacists.**
**For each technician, please use the section below.**

## Pharmacy Technician Application

**Name:** _____ **Suffix:** _____
First M.I. Last

**Nickname:** _____ **Name of Spouse:** _____

**Preferred Salutation,** (*check one*): [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Miss

**Are you a Certified Pharmacy Technician (CPhT)?** [ ] Yes [ ] No **Sex:** [ ] Female [ ] Male

**Are you interested in becoming certified?** [ ] Yes [ ] No **Date of Birth**:_____

**Home Address:** _____ **City:** _____ **State:** _____ **ZIP:** _____

**County:** _____ **Home Phone**: _____ **Home Fax:** _____

**Home E-Mail Address:** _____ **Work E-Mail Address:** _____

**Preferred Mailing Address:** [ ] Home [ ] Work **Preferred E-Mail:** [ ] Home [ ] Work

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**Signature:** _____ **Date:** _____

### Dues Amount Remittance
### Health System Corporate - $570.00 (Three Active Pharmacists)

Additional Individuals may be also enrolled at the following:
$165 for any additional staff pharmacist and $35 for each pharmacy technician.

**Please check method of dues payment:** ☐ Check # _____ ☐ Visa ☐ Mastercard

Card Number: _____ Expiration Date: _____ CVV Code: _____

Billing address with zip code for card: _____

Signature:_____ *(required for all charges)*

**Please mail the completed membership application and payment for membership dues to:**
**Pennsylvania Pharmacists Association 508 North Third Street, Harrisburg, PA 17101-1199**
Applications with credit card payments may be faxed to: 717-236-1618

Contribution or gifts to the Pennsylvania Pharmacists Association are not deductible as charitable contributions for federal income tax purposes. However, such payments may be deductible as business expenses or other provisions of the Internal Revenue Code. The Internal Revenue Service requires notification of the allocation of lobbying expense included in total membership dues which is not deductible. This amount is 15% of dues. Please consult with your accountant or tax attorney on these matters.