



Idaho State Pharmacy Association

P.O. Box 140117 * Garden City, Idaho 83714-0117

Phone: 208-841-2843

Membership Form

Name _____

Home address _____

City _____ State _____ Zip Code _____

Home Phone: _____ Work Phone: _____ Fax: _____

E-Mail Address: _____

Place of Employment: _____

ISPA MEMBERSHIP DUES: Membership is valid for one year from date of payment

(Please check appropriate category)

- _____ Active/Associate \$170.00
- _____ 1st Year Member \$ 85.00
- _____ Faculty \$ 55.00
- _____ Retired \$ 75.00
- _____ Technician/Support Personnel \$ 25.00
- _____ Student \$ 15.00 _____ Student Professional Year
- _____ 1st Year Pharmacist \$ 55.00
- _____ 2nd Year Pharmacist \$110.00

Enclosed is my check in the amount of \$ _____.

I wish to charge my 2009/2010 dues to my Visa/Mastercard - Exp. Date _____

Account _____

Signed: _____

I am enclosing an additional: [] \$500 [] \$250 [] \$100 [] \$50 [] Other _____

Please apply this contribution toward the ISPA Legislative Fund/General Support.

What are your top three pharmacy issues of concern?
