

Idaho State Pharmacy Association

816 W Bannock St., Suite 60 * Boise, Idaho 83702

Membership Form

Name _____

Mailing Address _____

City _____ State _____ Zip Code _____

Personal Phone: _____ Work Phone: _____

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	\$175.00	<i>*20% discount if ALL pharmacists within a store/ business join/are members</i>
_____	1st Year Member	\$ 85.00	
_____	Faculty	\$ 55.00	
_____	Retired	\$ 75.00	
_____	Technician/Support Personnel	\$ 25.00	
_____	Student	\$ 15.00	_____ Student Professional Year
_____	1 st Year Pharmacist	\$ 55.00	
_____	2 nd Year Pharmacist	\$110.00	

Enclosed is my check in the amount of \$ _____

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

Account _____ Security Code _____

Billing Address (if different from above): _____

Signed _____

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

Please apply this contribution toward (select one):

_____ ISPA Legislative Fund/General Support – assists in grassroots operations

_____ ISPA PAC – used for political contributions to legislative candidates

What are your top three pharmacy issues of concern?

ISPA – Serve * Promote * Advance