

MEMBERSHIP APPLICATION



MICHIGAN PHARMACISTS ASSOCIATION

Member Information

Prefix: Dr. Mr. Mrs. Ms. Miss Credentials: R.Ph. Pharm.D. JD M.A. CPhT B.S.

First Name: _____ Middle Initial: _____ Last Name: _____

Supplemental Information Male Female

Date of Birth: ____/____/____

Nickname: _____

Spouse's Name: _____
(if applicable)

Referred by: _____
(please include first and last name)

Membership in a local association is included with your MPA membership. Please select a local from the map on the reverse side.

Permanent Residence

(check here if this is the address you want to receive mail from MPA)

Home Address: _____

City/State/Zip: _____

Personal E-mail: _____

Home Phone Number: _____

Mobile Phone Number: _____

Business/Employment Information

(check here if this is the address you want to receive mail from MPA)

Practice/Employer's Name: _____

Business Address: _____

City/State/Zip: _____

Business E-mail: _____

Business Phone Number: _____

Business Fax Number: _____

Practice Section *(free with membership)*

- Consultant and Specialty Pharmacists of Michigan (CSPM)
- Michigan Society of Community Pharmacists (MSCP)
- Michigan Society of Health-System Pharmacists (MSHP)
- Michigan Society of Pharmacy Technicians (MSPT)

Educational Information

Degree Earned: _____

Month and Year: _____

Institution: _____

Membership Categories and Payment

Membership Categories

One-year membership effective through Dec. 31, 2019

	One-year membership
Active Pharmacist	<input type="checkbox"/> \$311
Joint with Spouse	<input type="checkbox"/> \$157
Limited Practice	<input type="checkbox"/> \$157
Retiree	<input type="checkbox"/> \$157
Academia	<input type="checkbox"/> \$157
New Practitioner	<input type="checkbox"/> \$100
Out-of-State Pharmacist	<input type="checkbox"/> \$157
Associate Member	<input type="checkbox"/> \$96
Pharmacy Technician	<input type="checkbox"/> \$72
Pharmacy Technician with FREE CE*	<input type="checkbox"/> \$83
Pre-Pharmacy or Technician Student	<input type="checkbox"/> \$10

Payment Information

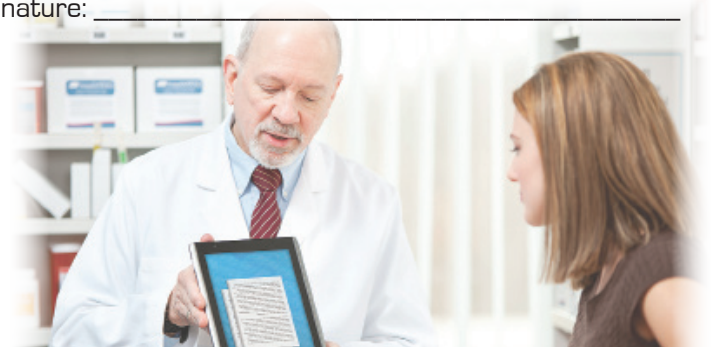
Full payment enclosed *(check payable to MPA)*

Credit Card: Visa MasterCard AMEX

Card Number: _____

Expiration Date: ____/____/____ CVV Code: _____

Signature: _____



If you have any questions, contact MPA at (517) 484-1466 or MPA@MichiganPharmacists.org.

Return your completed application with payment via fax (credit card only) to (517) 484-4893,
or mail to 408 Kalamazoo Plaza, Lansing, MI 48933.