



Rhode Island Pharmacists Association Membership Application

Date: _____

Name _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Home Fax _____

Email Address _____ Birth Date _____ Male Female

College(s) Attended _____ Year Graduated _____

Degree(s) _____ License Number(s) and State(s) of Licensure _____

Additional Certifications _____

Business Name _____

Business Address _____

City _____ State _____ Zip Code _____

Business Phone _____ Business Fax _____

Please send mail to: Home Business

Committed of Interest (choose all that apply): Communications ___ / Membership ___ / Continuing Education ___ / Awards ___ / Legislative ___

I hereby apply for: (*choose one*)

- | | |
|-----------------------------------------------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Active Pharmacist \$175 | <input type="checkbox"/> Associate Member \$175 |
| <input type="checkbox"/> New licenced pharmacist (first year) \$75 | <input type="checkbox"/> Retired Pharmacist \$75 |
| <input type="checkbox"/> Technician Associate \$30 | <input type="checkbox"/> Student \$10 |
| <input type="checkbox"/> Spouse Membership \$275 (first pharmacist \$175, second \$100) | |

Payment option: Check VISA Mastercard

Charge to: Card number _____

Expiration Date _____ Member Signature _____

Mail application to:
Rhode Island Pharmacists Association, 1643 Warwick Avenue, PMB 113, Warwick, RI 02889