Iowa Pharmacy Association
Membership Enrollment Form

Pharmacist • Retired • Resident • Associate • Technician

License #: ______________________ Date of Birth: ______________________

First Name: ______________________ Middle Initial: ______________

Last Name: ______________________ Suffix: ________ Gender: __________

Nickname: ______________________ Spouse Name: ______________________

College of Pharmacy Attended: ______________________________________

Graduation Date: ____________________ Degrees/Designations: ________________

Home Address: ____

City: ______________________________ State: __________ Zip: ___________

Home Phone Number: __________________ Cell Phone Number: __________________

Place of Employment: ____

Work Address: ____

Work City/State/Zip: ______________________ Work Phone Number: ______________

Work Fax Number:__________________Email Address: ________________________

Preferred Mailing Address:☐ Home ☐ Work

☐ *Do not include me in directory*

Are you an immunizing pharmacist? ☐ Yes ☐ No

Are you PCM trained? ☐ Yes ☐ No

Employment Status:

☐ Associate
☐ Technician
☐ Resident
☐ Retired
☐ Administrator
☐ Academia
☐ Other, please specify ___________
☐ Director
☐ Owner
☐ Manager
☐ Staff Pharmacist
☐ Relief

Primary Practice Type: ________________

Other Practice Types: *(please check all that apply)*

☐ Academia
☐ Acute Care
☐ Ambulatory/chain
☐ Ambulatory/clinic
☐ Ambulatory/independent
☐ Franchise
☐ Home Healthcare
☐ Home Infusion
☐ Hospital/inpatient
☐ Hospital/outpatient
☐ Industry
☐ Long Term Care
☐ Managed care/admin
☐ Managed care/clinic
☐ Other, please speficy ________________

Practice Interests: *(please check all that apply)* ☐ Legislative ☐ Legislative Alert Network ☐ IPRN ☐ Medicaid/Pharmacy Benefit Programs ☐ Public Affairs ☐ Professional Affairs

Membership Dues:

☐ Pharmacist - $205 ☐ Retired - $50 ☐ Resident - $105 ☐ Technician - $35 ☐ Associate - $205

☐ Iowa Pharmacy Foundation Contribution** - $25

***Contributions to the Iowa Pharmacy Foundation are optional.*

Total Due: $____________

Payment Options:

☐ Check ☐ Mastercard ☐ Visa ☐ American Express

Credit Card Number: ____

Exp. Date: ____________________ Verification # (last 3 digits on the back of the card):__________

Cardholder's Name: ____

Cardholder's Address: ____

Cardholder's City/State/Zip: ______________________________ ☐ Check if address is the same as home address

Signature: ____

Please return this form to:
Iowa Pharmacy Association
8515 Douglas Avenue, Ste 16
Des Moines, IA 50322
515-270-0713 (ph) ~ 515-270-2979 (fax)
www.iarx.org

For office use only:
A101- 3001-000 @ ______________
A000-2301-000 @ ______________
A101-3002-000 @ ______________
Ck#__________ Date____________