Iowa Pharmacy Association Membership Enrollment Form

Student Pharmacist Membership

First Name: ______________________________ Middle Initial: ____________

Last Name: __________________________ Suffix: _______ Gender: ________

Nickname: ______________________ Spouse Name: ______________________

College of Pharmacy: ____

Anticapted Graduation Date: ________________ Birthdate: ___________________

College Address: ____

Collge Address City/State/Zip: _______________________________________

College Phone Number: ________________ Cell Phone Number: ______________

Email Address: _______________________ Fax Number: ____________________

Permanent Address: ____

Permanent Address City/State/Zip: ____________________________________

Preferred Mailing Address: ☐ College ☐ Permanent ☐ *Do not include me in the directory*

Are you trained to adminster immunizations? ☐ Yes ☐ No

Membership Dues:

☐ Student Pharmacist (P1-P4) - $50

☐ 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: ____

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:
A101-3003-000 @ __________
A000-2301-000 @ __________
Ck#________ Date__________
ID #:____________________