



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 specify _____

Practice Interests: (please check all that apply)

- Medicaid/Pharmacy Benefit Programs
- Legislative
- Legislative Alert Network
- IPRN
- Public Affairs
- Professional Affairs

Membership Dues:

- Pharmacist - \$225
- Retired - \$100
- Resident - \$105
- Technician - \$45
- Associate - \$225
- 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	_____