



ASSOCIATION OF BLACK HEALTH SYSTEM PHARMACISTS

2910 Kerry Forest Pkwy., D4-393, Tallahassee, FL. 32309 (850) 894-4255

Membership Application - Change of Address

(Please print)

(Mr. Mrs., Dr., etc) First Name Initial Last Name

Business Name Business Phone (Area Code + #)

Business Mailing Address

City State ZipCode

Home Address

City State ZipCode

Home Phone: () FAX Number ()

Email Preferred Mailing Address: Home Business

New Member Sponsor Name: (The person who recruited and/or encouraged the member to join)

Last Name: First Name Initial/Middle

Current Job Position (Check One)

- Hospital Staff Pharmacist
- Assistant/Associate Director
- Supervisor/Manager
- Technician
- Clinical Pharmacist
- Community Pharmacist
- Pharmaceutical Industry
- Pharmacy Resident
- Director of Pharmacy
- College/Univ. Faculty
- Student or Intern
- Other _____

I would be interested in serving on the following committee(s):

- Awards
- Communications
- Educational Affairs
- Fund Raising
- Meetings
- Membership

Please check the membership category for which you are applying:

<input type="checkbox"/> Active (Pharmacist)	\$ 100.00	_____
<input type="checkbox"/> Associate (Non-Voting)	\$ 100.00	_____
<input type="checkbox"/> Corporate (For-Profit)	\$ 500.00	_____
<input type="checkbox"/> Institutional (Non-Profit)	\$ 100.00	_____
<input type="checkbox"/> Pharmacy Student/Intern	\$ 35.00	_____
<input type="checkbox"/> Pharmacy Technician	\$ 35.00	_____
<input type="checkbox"/> Donation*		_____
TOTAL		_____

*Non-Profit Org. Tax ID #59-2477500

Total Amount Enclosed \$ _____ Make checks payable to the *Association of Black Health-System Pharmacists* and mail, with this form to: **ABHP 2910 Kerry Forest Pkwy., D4-393, Tallahassee, FL. 32309;**
Fax (credit card only) to **850-894-4255.**

Charge to: AmEx ; Visa; MasterCard _____ **Exp:** _____

Date: _____