

ARIZONA ASSOCIATION OF PHARMACISTS OF INDIAN ORIGIN



MEMBERSHIP APPLICATION

Membership form for Year _____

Please complete the information below:

FAMILY (LAST) NAME: _____

FIRST NAME: _____ MIDDLE INITIAL: _____

EMAIL: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

WORK INFORMATION:

TITLE: _____ BUSINESS NAME: _____

Are you currently licensed to practice in the field of Pharmacy in Arizona? YES NO

Which of the following best represents your Practice Setting?

- | | |
|---|---|
| <input type="checkbox"/> Academia | <input type="checkbox"/> Independent Pharmacy (1-3 units) |
| <input type="checkbox"/> Association/Regulatory | <input type="checkbox"/> Mail service pharmacy |
| <input type="checkbox"/> Chain/Discount Pharmacy (4+ units) | <input type="checkbox"/> Managed Care Pharmacy |
| <input type="checkbox"/> Clinic (Outpatient) Pharmacy | <input type="checkbox"/> Nuclear Pharmacy |
| <input type="checkbox"/> Consultant Pharmacy | <input type="checkbox"/> Pharmaceutical Industry |
| <input type="checkbox"/> Federal Pharmacy (DOD, PHS, VA) | <input type="checkbox"/> Physician Office-Based Pharmacy |
| <input type="checkbox"/> Home/Long Term Care | <input type="checkbox"/> Supermarket Pharmacy |
| <input type="checkbox"/> Hospital / Institutional Pharmacy | <input type="checkbox"/> Other: _____ |
- (Please specify)

ANNUAL MEMBERSHIP TYPE:

- \$100 - Pharmacist - Individual
- \$160 - Pharmacist - Joint (Husband/Wife)
- \$50 - Retired Pharmacist
- \$25 - Pharmacy Technician
- \$25 - Pharmacy Student/Intern

- My Gift to APPIO (Optional)...\$ _____
- Method of Payment: Check
- Make Checks Payable to: Arizona Association Of Pharmacists of Indian Origin
- Mailing Address: 16211 N 99th Way, Scottsdale, AZ 85260

For more Information Visit us at: MyAAPIO.org