

Home

First: _____ MI: ___ Last: _____
 Credentials: _____ (Ex: RPh, BA, PhD)
 NABP ID: _____ DOB: _____ MMDD
 Street: _____
 City: _____
 State: _____ Zip + 4: _____ - _____
 Phone: (_____) _____ - _____
 Fax: (_____) _____ - _____
 Email: _____

Business

Business Name: _____
 Title/Position: _____
 Street: _____
 City: _____
 State: _____ Zip + 4: _____ - _____
 Phone: (_____) _____ - _____
 Fax: (_____) _____ - _____
 Email: _____

Who can we thank for referring you to IPhA:

Please indicate your preference for receiving IPhA communications

Postal Mail: Home Business

Email: Home Business

Fax: Home Business

IPhA Membership Type

- Regular Pharmacist Member\$275
- Associate Member (*non-pharmacist*)\$275
- Academic Member \$137.50
- Joint Member (*spouse of regular member*)\$137.50
 - New Pharmacist Practitioner 1 (*2024 graduate*)\$ 0
 - New Pharmacist Practitioner 2 (*2023 graduate*)\$110
 - New Pharmacist Practitioner 3 (*2022 graduate*)\$165
 - New Pharmacist Practitioner 4 (*2021 graduate*)\$220
- Out-of-State Pharmacist Member\$110
- Retired Pharmacist Member\$110
- Student\$20
- Technician Member\$40

Total Due: \$ _____

What piqued your interest in becoming a member?

- Ignite to Excite Campaign
(List approached by a student who attended:
 (Circle the school)
 CSU MWU Rossevelt RFUMS
 SIUE SLCOP UIC Chicago UIC Rockford)
- Friend/Colleague
- IPhA Certificate/CPE Program
- Social Media
- Local Association Event
- COP Presentation
- IPhA Annual Conference
- IPhA Website www.ipha.org
- Illinois Pharmacists Journal

What is your primary pharmacy practice setting?

- | | | | | |
|------------------------------------|---|---|--|---------------------------------------|
| <input type="checkbox"/> Chain | <input type="checkbox"/> Compounding | <input type="checkbox"/> Hospital/Health System | <input type="checkbox"/> Pharmacological | <input type="checkbox"/> Technician |
| <input type="checkbox"/> Clinical | <input type="checkbox"/> Government | <input type="checkbox"/> Independent | <input type="checkbox"/> Retired | <input type="checkbox"/> University |
| <input type="checkbox"/> Community | <input type="checkbox"/> Home Health Care | <input type="checkbox"/> Long Term Care | <input type="checkbox"/> Student | <input type="checkbox"/> Other: _____ |

Payment Method

- Check (Payable to IPhA)
- Credit Card: AMEX, MasterCard, Visa, Disc
 Acct #: _____
 Exp. Date (MM/YY): ___ / ___ CVV: _____
 Signature: _____ Zip Code: _____

Qualifications

Graduation Date: ___ / ___ / _____
 College/University: _____
 Degree: _____
 License #: _____ State: _____

Fax/Mail To: Illinois Pharmacists Association
 204 West Cook St. | Springfield, Illinois 62704-2526
Phone: (217) 522-7300 | **Fax:** (217) 522-7349
Email To: kimc@ipha.org