



National COMMUNITY PHARMACISTS Association

Application for NCPA Membership

Please print clearly.

Mr. Mrs. Ms. _____ Date of Birth _____

First Name _____

Middle Name _____

Last Name _____ Suffix (Jr., Sr., etc.) _____

Nickname/Preferred Name _____

R.Ph. P.D. Pharm.D. Ph.D. Student

Other _____

Pharmacy _____

Street Address _____

City _____ State _____ Zip _____

Work Telephone _____

Home Telephone _____

Work Fax Number _____

Preferred Email Address _____

Pharmacy Website URL _____

Social Security # _____

NCPDP#/NAPB# _____

Pharmacist License(s)

1. State _____ Number _____

2. State _____ Number _____

3. State _____ Number _____

School of Graduation _____

Month/Day/Year of Graduation _____

Join NCPA Today

BY PHONE: 800-544-7447 or 703-683-8200

BY FAX: 703-683-3619

BY MAIL: NCPA, 205 Daingerfield Road, Alexandria, VA 22314

BY INTERNET: www.ncpanet.org/ABOUTNCPA/memform.html

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NCPA Membership Categories

Active Member (Owner or Manager Pharmacist)

\$245/1 year \$440/2 years

\$635/3 years \$2,000/Lifetime

Number of stores: _____

Division of Home Health Care and Long-Term Care Pharmacy — \$75/year

NCPA Membership required. Membership in this Division includes *Regimen*, a bimonthly clinical newsletter, and *Alternate Site Pharmacist Online* — available only to Division Members at www.ncpanet.org.

Active Member Spouse (Pharmacist Spouse of Active Member) — \$95/year

Active Member's #: _____

Pharmacist Member (Staff Pharmacist) — \$150/year

Independent Chain Hospital

Other: _____

Recent Graduate (Up to three years after graduation) —

\$30/2002 \$60/2001 \$90/2000

Pharmacy Student — \$25/1 year \$40/2 years

\$60/3 years \$75/4 years \$100/5 years

Pharmacy Technician — \$75/year

Retired — \$60/year

Sustaining (Non-pharmacist Member) — \$120/year

Payment Information

Total membership dues: \$ _____

Enclosed is my check (*Payable to NCPA*).

Please bill me.

Please bill my credit card.

Visa MasterCard American Express

Name on Card _____

Card Number _____

Card Expiration Date _____

Signature _____

Today's Date _____

I understand that \$15 of my membership dues is allocated to my *America's Pharmacist* magazine subscription.

Signature (required) _____

Date _____