ASSOCIATION OF BLACK HEALTH SYSTEM PHARMACISTS

2910 Kerry Forest Parkway, Suite D4-393, Tallahassee, Florida 32309 • 888- 834-0603 *• www. myabhp.org*

Membership Application - Change of Address

(Please print)

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

____
Home Address

____
City State Zip Code

____
Home Phone FAX Number

____
Business Name Business Phone (Area Code + #)

____
Business Mailing Address

____
City State Zip Code

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 Council (s):

- ❑ Administrative Affairs
- ❑ Professional Affairs
- ❑ Educational Affairs
- ❑ Student Affairs
- ❑ Organizational Affairs
- ❑ Pharmacy Technicians

Please check the membership category for which you are applying:

	1 year	3 years	5 years	
❑ **Active (Pharmacist)**	❑ **$ 100.00**	❑ **$ 280.00**	❑ **$ 465.00**	_________
❑ **Associate (Non-Voting)**	❑ **$ 100.00**	❑ **$ 280.00**	❑ **$ 465.00**	_________
❑ **Pharmacy Student/Intern**	❑ **$ 35.00**	❑ **$ 85.00**	❑ **$ 145.00**	_________
❑ **Pharmacy Technician**	❑ **$ 35.00**	❑ **$ 85.00**	❑ **$ 145.00**	_________
❑ **ABHP Foundation Donation**				_________
❑ **Automatic Dues Renewal***				
TOTAL				_______________

**Dues may be renewed automatically on a yearly basis when you agree by signing the application to have your credit card billed. You may cancel your membership to the ABHP or choose to pay with a different payment method when you notify the ABHP in writing at least 60 days prior to the dues expiration date.*

Total Amount Enclosed $ ________________ Make checks payable to the ***Association of Black Health-System Pharmacists*** and mail, with this form to: **ABHP Membership**, *Association of Black Health-System Pharmacists, 13 Beauvoir Court, Rockville, MD 20855-1250* • 301-330-2043 • FAX *(Credit Card Only)* 850-512-1821.

Charge to: **Discover** **Master Card** **VISA** **Card Number**____

Cardholder's Signature____ **Date**__________________

To join online visit our web site at www.myabhp.org