ASSOCIATION OF BLACK HEALTH SYSTEM PHARMACISTS
2910 Kerry Forest Parkway, Suite D4-393, Tallahassee, Florida 32309 ● 850-894-4255 ● 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 Membersh**ip, *Association of Black Health-System Pharmacists, 13 Beauvoir Court, Rockville, MD 20855-1250* ● 305-585-1197 ● FAX *(Credit Card Only)* 301-947-3221

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

Cardholder's Signature_____ **Date**_____

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