WEST VIRGINIA SOCIETY of HEALTH-SYSTEM PHARMACISTS

MEMBERSHIP APPLICATION

Please Print

First Name: _____ Middle Initial: _____ Last Name: _____

Preferred E-Mail Address: _____

Pharmacy Practice Setting (select one):

- ☐ Academic
- ☐ Clinic
- ☐ Community
- ☐ DoD/VA
- ☐ Govt. Agency
- ☐ HMO/Managed Care
- ☐ Home Health Care
- ☐ Hosp. /Health-System
- ☐ Legal System
- ☐ Long Term Care
- ☐ Manufacturer/Wholesaler
- ☐ Retired
- ☐ Other: _____

Membership Dues:

Pharmacist	$110.00
Resident	$ 40.00
Technician	$ 25.00
Student	$ 0.00

Home Information:

Address: _____

City, State, Zip: _____

Phone: _____

Home County: _____

Select a Region:

☐ North ☐ Central ☐ South

Practice Information:

Company: _____

Check all that apply:

- ☐ Chief Pharmacy Officer
- ☐ Director
- ☐ Assistant Director
- ☐ Clinical
- ☐ Staff Pharmacist
- ☐ Clinical Coordinator
- ☐ Faculty
- ☐ Industry Rep
- ☐ Consultant
- ☐ Resident
- ☐ Technician
- ☐ Vice President
- ☐ Residency Program Director
- ☐ Other: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____ Cell: _____

Preferred Mailing Address: ☐ Business ☐ Home

Unless checked above, will default to business address.

Year of Graduation: _____

Year of Original Licensure/Registration: _____

Degrees/Certifications: _____

Join a Committee:

- ☐ Education
- ☐ Public Relations/Community Service
- ☐ Finance
- ☐ New Practitioner's Group
- ☐ Legislation
- ☐ Scholarship/Awards

Your Membership Investment:

Dues Amount (from above):

Membership $_____

Contributions $_____

I would like to contribute to the WVSHP Scholarship Fund, benefitting students attending Schools of Pharmacy in West Virginia

$ _____

TOTAL PAYMENT $_____

Make checks payable to WVSHP and return to:

WVSHP
PO BOX 590
Culloden, WV 25510

Referred by _____