



PARD Membership Application
(PLEASE PRINT)

- 1. Your Name: _____ Title: _____
- 2. Name of Pharmacy/Organization: _____
- 3. Corporate Name of Pharmacy: _____
- 4. Mailing Address: _____
- 5. City: _____ State: _____ Zip: _____
- 6. Telephone Number: _____ Alternate/cell: _____ Fax: _____
E-Mail: _____
- 7. Other County Association Membership: _____
- 8. Are You a Licensed Pharmacist? YES: _____ NO: _____
- 9. Graduated Month/Year: _____ School: _____
- 10. PA Pharmacist License # : _____ Pharmacy License #PP: _____
- 11. Store NABP#: _____ NPI#: _____

MEMBERSHIP CATEGORIES

Category "A"/Active-Storeowner – Inside/Outside Phila. (Voting Membership) – 1 st five locations:	\$300.00
Category "A-1" discount rate 6+ locations:	\$100.00
Category "C"/Associate Member, i.e., Licensed Pharmacists:	\$100.00*
Category "F"/Retiree (R.Ph. or Non-R.Ph.):	\$100.00*
Category "H"/Manufacturer or Wholesaler Representative:	\$100.00*
Category "I"/Corporate or Organizational:	\$1500.00*

*Indicates Non-Voting Status

I hereby apply for the following membership category: _____ = \$ _____

Signature: _____ Date: _____

Mail completed Membership Application and dues payment payable to: PARD,
2417 Welsh Road
Ste #21, Box #342
Philadelphia, PA 19114

Please check method of payment: Check Enclosed: ___ Visa: ___ MasterCard: ___ AMEX: ___ Discover: ___

Card #: _____ Expiration: _____ Security Code: _____ Address #: _____ Zip code: _____

Signature (credit card only): _____

The following information is important for us to maintain accurate contact with Legislators:

For Legislative Issues

Home Address: _____

City: _____ State: _____ Zip: _____

County: _____

Home Phone: _____ Home Fax: _____

If You Know:

Pa House of Representatives District: _____

Pa Senate District: _____

Representative Name: _____

Senator Name: _____

US House of Rep. Name: _____