

AMCP MEMBERSHIP APPLICATION

MEMBER INFORMATION

Mr. Ms. Mrs. Dr.

FIRST NAME _____ LAST NAME _____

TITLE _____

ORGANIZATION NAME _____

ORGANIZATION ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

SEND ALL MAILINGS TO MY: Company Address Home Address

WORK TELEPHONE _____ FAX _____

HOME TELEPHONE _____ CELLULAR TELEPHONE _____

EMAIL ADDRESS (PRIMARY) _____ EMAIL ADDRESS (SECONDARY) _____

PLEASE ENTER THE AMCP MEMBER WHO REFERRED YOU FOR MEMBERSHIP (IF APPLICABLE).

REFERRED BY _____

DEMOGRAPHIC INFORMATION

PLEASE TELL US:

I. What degrees/designations do you hold?

- | | |
|------------------------------------------------|---------------------------------|
| <input type="checkbox"/> BS Pharmacy | <input type="checkbox"/> PharmD |
| <input type="checkbox"/> MPA | <input type="checkbox"/> MPH |
| <input type="checkbox"/> PhD | <input type="checkbox"/> JD |
| <input type="checkbox"/> MBA | <input type="checkbox"/> RPh |
| <input type="checkbox"/> MD | <input type="checkbox"/> RN |
| <input type="checkbox"/> Other (specify) _____ | <input type="checkbox"/> DO |

II. Which of the following best describes your employer? (check one)

- | | |
|-------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> ACO/PCMH/Emerging Care Model | <input type="checkbox"/> Medical/Physician Group |
| <input type="checkbox"/> Adherence Service Provider | <input type="checkbox"/> MTM Service |
| <input type="checkbox"/> College/University | <input type="checkbox"/> PBM or Mail Service |
| <input type="checkbox"/> Community Pharmacy | <input type="checkbox"/> Pharmaceutical Industry |
| <input type="checkbox"/> Consulting Firm | <input type="checkbox"/> Press |
| <input type="checkbox"/> Government/Military | <input type="checkbox"/> Research/Analytics |
| <input type="checkbox"/> Health Plan | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Hospital/Health System | <input type="checkbox"/> Specialty Pharmacy |
| <input type="checkbox"/> Managed Markets Agency | <input type="checkbox"/> Technology/IT |
| <input type="checkbox"/> Medical Education | <input type="checkbox"/> Wholesale/Distribution/GPO |
| <input type="checkbox"/> Other (specify) _____ | |

III. Which of the following best describes your job function(s)? (check one)

- | | |
|----------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Academic Faculty/Staff | <input type="checkbox"/> Pharmacy Director/Assistant Director |
| <input type="checkbox"/> Case Manager | <input type="checkbox"/> Pharmacy Manager |
| <input type="checkbox"/> Clinical Pharmacist/Coordinator | <input type="checkbox"/> Pharmacy Technician |
| <input type="checkbox"/> Consultant | <input type="checkbox"/> Pharmacy/Provider Network Management |
| <input type="checkbox"/> Contracting/Distribution/Supply Chain | <input type="checkbox"/> President/CEO |
| <input type="checkbox"/> C-Suite Member/VP | <input type="checkbox"/> Product/Program Devel |
| <input type="checkbox"/> Formulary/Drug Use Mgmt | <input type="checkbox"/> Prof./Trade Relations |
| <input type="checkbox"/> Graduate Student | <input type="checkbox"/> Research-Outcomes/Clinical |
| <input type="checkbox"/> Legal Affairs/Govt Affairs | <input type="checkbox"/> Resident/Fellow |
| <input type="checkbox"/> Marketing/Sales | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Medical Affairs | <input type="checkbox"/> Staff/Operations Pharmacist |
| <input type="checkbox"/> Medical Director/CMO | <input type="checkbox"/> Student |
| <input type="checkbox"/> Not Employed | |
| <input type="checkbox"/> Other (specify) _____ | |

IV. Indicate your license or eligibility for licensure below. (check one)

- | | |
|---------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> MD | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Not Applicable | <input type="checkbox"/> Physician Assistant |
| <input type="checkbox"/> Nurse | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Pharmacy Technician |

AMCP dues are not deductible as a charitable contribution for U.S. federal income tax purposes, but may be deductible as a business expense. AMCP estimates that 15% of your dues are not deductible because of AMCP's lobbying activities on behalf of its members. AMCP contributes \$5 of all Active and Associate annual dues to the AMCP Foundation. AMCP memberships are not transferable or refundable.

ANNUAL MEMBERSHIP RATES

Active Member \$275 per year
Active membership – must be a pharmacist, physician, nurse, nurse practitioner, or physician assistant.

REQUIRED FOR PHARMACISTS:

SCHOOL/COLLEGE OF PHARMACY _____ GRADUATION YEAR _____ STATE(S) LICENSED _____

Associate Member \$440 per year

Pharmacy Technician \$145 per year

Student Pharmacist Member \$45 per year

REQUIRED: GRADUATION DATE (MONTH/YEAR) _____ SCHOOL/COLLEGE OF PHARMACY _____

Resident/Fellow/Graduate Student Member \$100 per year

REQUIRED: COMPLETION DATE (MONTH/YEAR) _____ SITE _____

SCHOOL/COLLEGE OF PHARMACY _____ GRADUATION YEAR _____ STATE(S) LICENSED _____

Active Duty in Uniformed Services deduct 50% from Active or Associate Member Dues per year

Retired Rate contact AMCP at memberservices@amcp.org for details

METHOD OF PAYMENT

Check made payable to AMCP for \$ _____ (in US funds drawn on a US bank)

Charge \$ _____ to my credit card: Visa MasterCard American Express

CARD NUMBER _____

EXPIRATION DATE _____

CARDHOLDER PRINTED NAME _____

CARDHOLDER SIGNATURE _____