



# PSW Membership Application

Name RPh  PharmD  CPhT  Other

Business name \_\_\_\_\_

Home address \_\_\_\_\_

Business address \_\_\_\_\_

City State Zip

City State Zip

Primary Phone \_\_\_\_\_

Phone Fax

Primary E-mail address \_\_\_\_\_

E-mail address \_\_\_\_\_

Which is your preferred mailing address?  home  business

Which is your preferred e-mail address?  home  business

*I consent to receive communications sent by or on behalf of the Pharmacy Society of Wisconsin by any method used by PSW.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Membership Type

- Pharmacist ..... \$280
- 1st Year Pharmacist\* ..... Complimentary
- 2nd Year Pharmacist\* ..... \$155
- 3rd Year Pharmacist\* ..... \$205
- Retired Pharmacist ..... \$130
- Technicians ..... \$75
- Students ..... \$15
- Associate ..... \$280

*\*Corresponds to year in practice.*

*Note: Many employers have policies in place to pay for all or part of your member dues in a professional pharmacy association. Ask your employer if this benefit is available to you.*

Total Payment \$ \_\_\_\_\_

### Method of Payment:

*Prices subject to change.*

- My check is enclosed made payable to the *Pharmacy Society of Wisconsin*
- Please charge to my  Visa  Mastercard
  - American Express  Discover

Card # \_\_\_\_\_

Expiration Date \_\_\_\_\_

3 or 4 digit card verification number \_\_\_\_\_

Name on the Card \_\_\_\_\_

Billing Address \_\_\_\_\_

Signature \_\_\_\_\_



### Four ways to register

**Mail:** PSW, 701 Heartland Trail  
Madison, WI 53717

**Call:** 608.827.9200

**Fax:** 608.827.9292

**Web:** [www.pswi.org/membership](http://www.pswi.org/membership)

For Office Use Only

check # \_\_\_\_\_ date entered \_\_\_\_\_