Today's Date:_____

PSW Membership Application

Name RPh ❒ PharmD ❒ CPhT ❒ Other ❒

Home address

City State Zip

Primary Phone

Primary E-mail address

Business name

Business address

City State Zip

Phone Fax

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

- ❒ Active Pharmacist $240
- ❒ 1st Year Pharmacist* ..... *Complimentary*
- ❒ 2nd Year Pharmacist* $120
- ❒ 3rd Year Pharmacist* $180
- ❒ Joint (Husband & Wife) Pharmacist Membership $360
- ❒ Retired Pharmacist $120
- ❒ Technicians $65

**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_____

PSW Pharmacy Society of Wisconsin

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

For Office Use Only

check #_____ date entered_____

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