Today's Date:____________

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 $275
- ❐ 1st Year Pharmacist* ....*Complimentary*
- ❐ 2nd Year Pharmacist* $150
- ❐ 3rd Year Pharmacist* $200
- ❐ Retired Pharmacist $125
- ❐ Technicians $75
- ❐ Students $15
- ❐ Associate $275

**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

For Office Use Only

check #______________ date entered______________

rev 10/22