



# HPhA Membership Form

Mail to: HPhA Membership Committee – PO Box 1510 – Aiea, HI 96701

HPhA ID# (office use) \_\_\_\_\_

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Island \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell/pgr \_\_\_\_\_ Email \_\_\_\_\_

Bus Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Island \_\_\_\_\_ Zip \_\_\_\_\_

Bus Phone \_\_\_\_\_ Bus Fax \_\_\_\_\_ Email \_\_\_\_\_

**Employer**

<input type="checkbox"/> Castle	<input type="checkbox"/> HMC	<b>Practice Setting</b>	<input type="checkbox"/> Retail Chain	<input type="checkbox"/> Reg/Gov/Academia
<input type="checkbox"/> HPH	<input type="checkbox"/> Safeway		<input type="checkbox"/> Retail Independent	<input type="checkbox"/> Industry
<input type="checkbox"/> Kaiser	<input type="checkbox"/> Times		<input type="checkbox"/> Retail Amb/Clinic/Outpt	<input type="checkbox"/> Home Health Care
<input type="checkbox"/> K-Mart	<input type="checkbox"/> Tripler		<input type="checkbox"/> Long Term Care	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Kapiolani	<input type="checkbox"/> Walmart		<input type="checkbox"/> HMO/Managed Care	
<input type="checkbox"/> Longs Drug	<input type="checkbox"/> Pharmicare		<input type="checkbox"/> Hospital	
<input type="checkbox"/> Other: _____				

**Degree(s)** (check all that apply)

<input type="checkbox"/> Pharm D	<input type="checkbox"/> MBA	<b>Other Prof Memberships:</b> (check all that apply)	<input type="checkbox"/> APhA	<input type="checkbox"/> HIP
<input type="checkbox"/> BS pharmacy	<input type="checkbox"/> MS		<input type="checkbox"/> ASHP	<input type="checkbox"/> ACCP
<input type="checkbox"/> CPhT	<input type="checkbox"/> MPH		<input type="checkbox"/> NCPA	<input type="checkbox"/> HAH
<input type="checkbox"/> Tech	<input type="checkbox"/> RN		<input type="checkbox"/> ASCP	<input type="checkbox"/> AMCP
<input type="checkbox"/> Other BS	<input type="checkbox"/> PhD		<input type="checkbox"/> NACDS	<input type="checkbox"/> Other: _____
<input type="checkbox"/> BA	<input type="checkbox"/> Other: _____			

**Member Type**

<input type="checkbox"/> Pharmacist (\$190)	<b>Please check your areas of interest:</b>	<b>Are you a new member?</b> Y / N	
<input type="checkbox"/> Medical Rep, non-pharmacists (\$75)		<input type="checkbox"/> Awards Committee	<b>Are you a CDE (Certified Diabetes Educator)?</b> Y / N
<input type="checkbox"/> Academia, non-pharmacists (\$75)		<input type="checkbox"/> Programs/CE Committee	<b>Are you an AE-C (Certified Asthma Educator)?</b> Y / N
<input type="checkbox"/> Regulatory (\$75)		<input type="checkbox"/> Finance Committee	<b>Are you BCPS certified?</b> Y / N
<input type="checkbox"/> Other Health Prof (\$75)		<input type="checkbox"/> Government Affairs Committee	<b>Are you a CDM (Certified Disease Manager)?</b> Y / N
<input type="checkbox"/> Technician (\$65)		<input type="checkbox"/> Membership Committee	
<input type="checkbox"/> Resident (\$75)		<input type="checkbox"/> Nominations Committee	
<input type="checkbox"/> Student (\$25)	<input type="checkbox"/> Newsletter		
	<input type="checkbox"/> Scholarship Committee		
	<input type="checkbox"/> Other: _____		

I am interested in joining the Hawaii Academy of Health-System Pharmacists (HAHSP), an academy of HPhA. Membership is free if you are a current HPhA member in good standing:  Yes  No  I already joined

What continuing education topic is of interest to you? \_\_\_\_\_

**May we give your contact information to?**

Professional Organizations to inform you about their CE Activities	Y / N
Other Organizations requesting your demographic information	Y / N

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

**Please complete the section below for accounting purposes:** Make checks payable to Hawaii Pharmacists Association

Name: \_\_\_\_\_ Pd Date: \_\_\_\_\_

Check #: \_\_\_\_\_ Amount: \_\_\_\_\_

Purpose of payment: (check all that apply)  Membership Dues  Other Program Event  Other

### HPhA Member Receipt: Detach this bottom portion for your records

Name:	Date:
Chk #:	Amount:

The Hawaii Pharmacists Association is a 501 (c) (6) non-profit trade association, as such, contributions to the Association are not tax deductible as charitable donations.

Updated July 2009

HPhA – PO Box 1510 – Aiea, HI – 96701



HAWAII PHARMACISTS ASSOCIATION