

Virginia Society of Health-System Pharmacists

9610 Jomar Drive, Fairfax, VA 22032

Ph. (800) 613-8747 * Fax (703) 323-5233 * Email VSHP@aol.com * Website <http://www.vshp.org/>

Personal Data		
Name _____		
Address _____		
City, St Zip _____		
Home Phone () _____		Email _____
Date of Birth ____/____/____	Social Security ____-____-____	Sex: M / F
VA State License Number _____		Recruited By _____

Practice Site		
Name _____		
Address _____		
City, St Zip _____		
Home Phone () _____		Fax _____
Home Phone () _____		Email _____
Type of Practice Site (please select one)	Job Title (please select one)	Specialty Area of Practice (please select one)
<input type="checkbox"/> Hospital <input type="checkbox"/> Managed Care <input type="checkbox"/> Home Health Care <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Community Pharmacy/Retail <input type="checkbox"/> School of Pharmacy <input type="checkbox"/> Government <input type="checkbox"/> Industry <input type="checkbox"/> Other: _____	<input type="checkbox"/> Director of Pharmacy <input type="checkbox"/> Assist or Assoc Director <input type="checkbox"/> Staff Pharmacist <input type="checkbox"/> Clinical Coordinator <input type="checkbox"/> Other Superv Position <input type="checkbox"/> Clinical Pharm - Specialist <input type="checkbox"/> Consultant Pharmacist <input type="checkbox"/> Faculty <input type="checkbox"/> Resident/Fellow <input type="checkbox"/> Technician <input type="checkbox"/> Student/Intern <input type="checkbox"/> Other: _____	<input type="checkbox"/> Acute/Critical Care <input type="checkbox"/> Admin/Management <input type="checkbox"/> Ambulatory Care <input type="checkbox"/> Clinical <input type="checkbox"/> Consulting <input type="checkbox"/> Disease Management <input type="checkbox"/> Drug Information <input type="checkbox"/> Endocrinology <input type="checkbox"/> Geriatrics <input type="checkbox"/> Home Health/Infusion <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Inpatient <input type="checkbox"/> Long Term <input type="checkbox"/> Mental Health <input type="checkbox"/> Nuclear Pharmacy <input type="checkbox"/> Oncology <input type="checkbox"/> Pediatrics/Neonatology <input type="checkbox"/> Pharmacotherapy <input type="checkbox"/> Research <input type="checkbox"/> Sales <input type="checkbox"/> Women's Health/OBGyn <input type="checkbox"/> Other: _____

Membership

Membership Category (please select one)	Local Chapter (please select one)	
<input type="checkbox"/> Active \$ 95.00 <input type="checkbox"/> Joint* \$ 150.00 <input type="checkbox"/> Associate \$ 95.00 <input type="checkbox"/> Resident/Fellow \$ 35.00 <input type="checkbox"/> Technician \$ 25.00 <input type="checkbox"/> Retired \$ 25.00 <input type="checkbox"/> Student* \$ 10.00 Anticipated yr of graduation: _____	<input type="checkbox"/> Region 1 <input type="checkbox"/> Region 2 <input type="checkbox"/> Region 3 <input type="checkbox"/> Region 4 <input type="checkbox"/> Region 5 <input type="checkbox"/> Region 6 <input type="checkbox"/> Region 7	

*If applying for joint membership, please complete an application form for self and 1 spouse. If applying for student membership, please include a photocopy of current student I.D.

Send completed application and check made payable to VSHP to 9610 Jomar Drive, Fairfax, VA 22032.