Mississippi Independent Pharmacies Association (MIPA)
Membership Application

Pharmacy Information:

Name on License of Location with the Mississippi State Board of Pharmacy (if applying as a Membership Group, list each Independent Pharmacy):

1. _____ License #: _____

Address _____

Phone/Fax_____ County: _____

2. _____ License # _____

Address _____

Phone/Fax_____ County: _____

3. _____ License # _____

Address _____

Phone/Fax_____ County:_____

Wholesaler Information:

Primary wholesaler: _____ _____

Secondary wholesaler: _____

Owner Information:

Name of Owner: _____

Principal Business Address_____

_____

Phone/Fax/Email_____

Will you be the Membership Representative to MIPA (responsible for voting, receiving notices, and representing the Member in all Membership matters)? yes____ no____

If no, who will be the Membership Representative? _____

Address _____

Phone/Fax/Email_____

By signing this Agreement, the undersigned, as the duly authorized representative of the Member does agree to follow all of the rules, regulations and requirements established by the Articles of Incorporation and By-Laws of the Mississippi Independent Pharmacies Association (the Corporation) and to pay the required monthly Assessed Amount as provided for from time to time in the By-Laws of this Corporation.

_____ _____

Signature of Owner Date

_____ _____

Signature of Authorized Representative Date
(If someone other than the Owner)

Please return completed form

Mississippi Independent Pharmacies Association
4209 Lakeland Drive, Suite 399
Flowood, MS 39232
888-957-0007 phone 866-957-0043 fax