



Associate Membership Application Form

Name: _____

Address: _____

City/State/Zip: _____ County: _____

Phone: _____ Fax: _____

Cell Phone: _____ Email: _____

Position at Pharmacy:

____ Pharmacist ____ Pharmacy Tech ____ Other staff

Pharmacy: _____

Address: _____

City/State/Zip: _____ County: _____

Phone: _____ Fax: _____

Associate Member Agreement

Annual Membership Dues: \$150

I certify that I am a licensed pharmacist, pharmacy technician, or other staff employed by a current MIPA member pharmacy. I understand that Associate Membership is a non-voting membership within Mississippi Independent Pharmacies Association (MIPA). By signing below, I agree to support MIPA's mission, abide by its Articles of Incorporation and Bylaws, and pay the annual Associate Membership dues.

Signature of Associate Member _____

Date _____

Send completed application and payment to P.O. Box 794, Madison, MS 39130

or complete and pay online: www.mipa.ms

For additional information call: call 601-957-0007 or Email awilson@mipa.ms