



Florida Independent Pharmacy Network

"Serving The Interests Of Independent Pharmacies In Their Endeavor to Better Serve Their Communities"

MEMBERSHIP APPLICATION

NAME _____ PHARMACY _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE _____ FAX _____ E-MAIL _____

MEMBERSHIP CATEGORIES & DUES

PHARMACY OWNER - \$250 PROFESSIONAL ASSOCIATE - \$150 CORPORATE MEMBER - \$300

METHOD OF PAYMENT

CHECK (*Make check payable to FIPN*) CREDIT CARD

ACCEPTED CREDIT CARDS: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

NAME ON CARD: _____ CREDIT CARD #: _____

CVC CODE: _____ EXPIRATION DATE: _____ AMOUNT OF PAYMENT: \$ _____

SIGNATURE: _____

PLEASE EITHER MAIL OR FAX TO: FELISHA SELLERS
ACCOUNTING MANAGER
FIPN MEMBERSHIP
3375-I CAPITAL CIRCLE, NE.
TALLAHASSEE, FL 32308
FAX #: (850) 895-3051

Thank you!

Processed by

PPSC