Commonwealth Pharmacists Association

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(Founded 1970)

APPLICATION FOR ASSOCIATE MEMBERSHIP

PLEASE COMPLETE IN BLOCK CAPITALS

NAME _____ **TITLE** _____

ADDRESS_____

_____

_____

DAYTIME TELEPHONE NUMBER_____**FAX**_____

E-MAIL

Annual Membership Fee	**£ 15.00**
Pharmaid Donation (suggestion £10)	**£**
Distance Education (suggestion £20)	**£**
	_____
Total	**£**

BY CHEQUE

I enclose cheque / postal / money order for: £ _____

Payable to: **The Commonwealth Pharmacists Association**

BY DEBIT OR CREDIT CARD

SWITCH ☐ **VISA** ☐ **Matercard** ☐ **Eurocard** ☐

Switch issue no _____ **Expiry date** _____

My Card number is | | | | | | | | | | | | | | | | | | **Amount to be Debited £** _____

Expiry date _____

Name on Card_____**Signature** _____ **Date**_____

If the address for the card is different from that given above, please give that address below:

_____

_____

Please check that you have provided the expiry date for your card

If you reside in the UK would you please give the security code on the reverse of the card together with your house number, house name and post code. This is a requirement by the company that processes the cards on behalf of CPA.

Security Code _____ **House No/ House name**_____ **Post Code** _____