



*Wichita Academy of Pharmacists  
Membership Application*

**Name & Address** \_\_\_\_\_ **Date** \_\_\_\_\_

**Name** \_\_\_\_\_ **Home Phone** \_\_\_\_\_

**Address** \_\_\_\_\_  
street city zip code

**E-mail Address** \_\_\_\_\_

**Place of Employment**

**Employer:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_

**Employer Phone:** \_\_\_\_\_

**Pharmacy Registration**

**States Registered:** \_\_\_\_\_ **Registration Number:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Education**

**University:** \_\_\_\_\_ **Degree:** \_\_\_\_\_ **Year Graduated:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Professional and Social Organizations**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Send completed  
form to:**

**The Wichita Academy of Pharmacists  
P. O. Box 3711  
Wichita, KS 67201-3711  
Membership Dues: \$120 per year**