University of Pittsburgh School of Pharmacy
Student College of Clinical Pharmacy
Membership Application 2018-2019

First name/M.I.:______________________ Last Name:___________________________________

Date of Graduation (month/year):_____________________________
E-mail Address:____________________________ Phone Number:_______________________

Preferred Mailing Address: Home/School (Please circle one.)
Street Address ____
City/State/Zip ____

<u>If National ACCP Member:</u>
Date of Birth: _______________________
National ACCP Membership ID: ____
Exp Date: _____________________ PRNs Joined: ____

<u>Enclose $10 CASH or CHECK payable to the University of Pittsburgh</u>
(If paying for local membership only; local fee waived for national ACCP members)