

Please type or print clearly. *Indicates a required field.

COMPANY INFORMATION

Company Name*

Street Address*

City*

State/Province*

Zip*

Country

Telephone*

Fax*

Primary Business Contact*

Job Title*

Check here if address is same as above, if not please add below.

Telephone*

Email*

Please check here if your company is hospital owned

of Licensed Compounding Pharmacy Location _____

Your provider membership entitles any of the employees you select to receive membership benefits including their own password for the website. You may submit a roster at anytime by calling 703-549-3740 or visiting www.nhia.org/roster.

Select/complete desired payment method below:

Enclosed is a check** (# _____) made payable to NHIA.

Charge: Visa MasterCard
 American Express Discover
 \$Amount _____

Account Number

Exp. Date _____

Billing Zip-Code _____

Signature (required)

Name on Card

** Checks must be made payable in U.S. dollars to NHIA and mailed to: 100 Daingerfield Road, Alexandria Virginia, 22314 or mail to address below

Mail: NHIA c/o United Bank
PO Box 222831
Chantilly, VA 20153-2831

Fax: 888-206-1532

Questions: Call NHIA's Membership Department at 703-549-3740, or email info@nhia.org

NHIA Dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense. The percentage of dues used for lobbying by NHIA is not deductible as a business expense. NHIA allots 10% of its dues for lobbying.

Select your organization's net infusion sales from the list below (based upon the following definition: "Net revenue" refers to an organization's total net revenue from infusion and injectable drugs, as well as enteral and parenteral nutrition therapies)—and kindly remit determined dues category:

Member Net Sales:

Dues Category:

<input type="checkbox"/> Less than \$500,000	\$800
<input type="checkbox"/> \$500,000 – \$999,999	\$1,200
<input type="checkbox"/> \$1 million – \$2.99 million	\$1,800
<input type="checkbox"/> \$3 million – \$5.99 million	\$2,500
<input type="checkbox"/> \$6 million – \$8.99 million	\$4,000
<input type="checkbox"/> \$9 million – \$11.99 million	\$5,675
<input type="checkbox"/> \$12 million – \$14.99 million	\$6,750
<input type="checkbox"/> \$15 million – \$19.99 million	\$9,000
<input type="checkbox"/> \$20 million – \$29.99 million	\$12,000
<input type="checkbox"/> \$30 million – \$49.99 million	\$18,000
<input type="checkbox"/> \$50 million – \$99.99 million	\$27,500
<input type="checkbox"/> \$100 million – \$499.99 million	\$65,000
<input type="checkbox"/> \$500 million – \$999.99 million	\$100,000
<input type="checkbox"/> \$1 billion and above.....	\$120,000

Authorized Signature (Required)

By signing this invoice I affirm that this company is an infusion provider and the Dues Category selected above correctly represents the organization's Net Infusion Sales.

Please list additional staff to be added to your NHIA membership.

Dr. Ms. Mr. Full Name: _____

RPh PharmD RN Other _____

Company (must be same as company on application): _____

Check here if Company name and contact is the same as listed on application

Job Title: _____

Street Address: _____

Company Address Only _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

E-Mail: _____

Dr. Ms. Mr. Full Name: _____

RPh PharmD RN Other _____

Company (must be same as company on application): _____

Check here if Company name and contact is the same as listed on application

Job Title: _____

Street Address: _____

Company Address Only _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

E-Mail: _____

Dr. Ms. Mr. Full Name: _____

RPh PharmD RN Other _____

Company (must be same as company on application): _____

Check here if Company name and contact is the same as listed on application

Job Title: _____

Street Address: _____

Company Address Only _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

E-Mail: _____

Primary Job Function (check one)

- Billing/Reimbursement – A/R Manager
- Case Manager
- Consultant
- Dietician
- Discharge Planner
- Educator
- Financial Officer
- Government
- Human Resources Professional
- Manager

- Nurse
- Operations
- Owner/CEO
- Pharmacist
- Pharmacy Technician
- Physician
- Retired
- Sales & Marketing Professional
- Student
- Technology/IT
- Trustee/Board of Director
- Other

This is the appropriate employee to contact regarding the following NHIA communications or activities:

- Legislative/Government Affairs
- Sales/Marketing
- Day-to-day Operations Manager
- Membership
- Primary Pharmacy Clinician
- Nursing Supervisor

Primary Job Function (check one)

- Billing/Reimbursement – A/R Manager
- Case Manager
- Consultant
- Dietician
- Discharge Planner
- Educator
- Financial Officer
- Government
- Human Resources Professional
- Manager

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- Membership
- Primary Pharmacy Clinician
- Nursing Supervisor

Please make copies of this form to add additional staff.



Branch Locations & Subsidiaries

Complete this form if your company has multiple branch locations and or subsidiaries. This information will allow NHIA to appropriately connect each member to their respective locations.

Branch Subsidiary

BRANCH/SUB NAME _____

MAILING ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

PHONE (____) _____ **FAX** (____) _____

BRANCH MANAGER _____

Branch Subsidiary

BRANCH/SUB NAME _____

MAILING ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

PHONE (____) _____ **FAX** (____) _____

BRANCH MANAGER _____

Branch Subsidiary

BRANCH/SUB NAME _____

MAILING ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

PHONE (____) _____ **FAX** (____) _____

BRANCH MANAGER _____

CORPORATE OFFICE USE ONLY

Date ____ / ____ / ____

Completed By _____ Title _____