
NAME OF ORGANIZATION

ADDRESS

CITY

STATE

ZIP

PHONE

FAX

E-MAIL

WEB PAGE

MAILING ADDRESS (IF DIFFERENT)

CITY

STATE

ZIP

1. Organization — Products Offered

(Check all that apply)

- PBM
- Mail Service Pharmacy
- Specialty Pharmacy
- PBA
- Utilization Review Organization (URO)
- Third Party Administrator (TPA)
- Disease Management
- Other — Please Describe:

2. Participation in Government Programs

- Medicaid Contract
- Medicare Part D
- FEHBP
- TRICARE

3. Tax Status

- For profit
- Non-profit

4. Total annual prescription volume

*Total annual prescription volume =
Retail scripts + specialty scripts + (mail scripts x 3)

5. Ownership

Is your organization owned (e.g., through majority stock ownership) or controlled (e.g., by majority representation on your Board of Directors) by another organization? For profit

- Yes
- No

If yes, please name the organization and explain the relationship to your organization.

Please identify key staff contacts at your organization within the following areas.

Please note on a separate sheet if contact address is different from address listed on previous page. Also, please indicate which PCMA communications each individual should begin receiving.

Chief Executive:

NAME	TITLE	
PHONE	E-MAIL	
<input type="radio"/> PCMA SmartBrief	<input type="radio"/> PCMA conference communications	<input type="radio"/> Press releases

Assistant to President/Chief Executive:

NAME	TITLE	
PHONE	E-MAIL	
<input type="radio"/> PCMA SmartBrief	<input type="radio"/> PCMA conference communications	<input type="radio"/> Press releases

Finance/CFO:

NAME	TITLE	
PHONE	E-MAIL	
<input type="radio"/> PCMA SmartBrief	<input type="radio"/> PCMA conference communications	<input type="radio"/> Press releases

Operations/COO:

NAME	TITLE	
PHONE	E-MAIL	
<input type="radio"/> PCMA SmartBrief	<input type="radio"/> PCMA conference communications	<input type="radio"/> Press releases

Chief Pharmacy Officer:

NAME	TITLE	
PHONE	E-MAIL	
<input type="radio"/> PCMA SmartBrief	<input type="radio"/> PCMA conference communications	<input type="radio"/> Press releases

IT/Chief Information Officer:

NAME	TITLE	
PHONE	E-MAIL	
<input type="radio"/> PCMA SmartBrief	<input type="radio"/> PCMA conference communications	<input type="radio"/> Press releases

Government Affairs — Federal Issues:

NAME _____ TITLE _____

PHONE _____ E-MAIL _____

PCMA SmartBrief PCMA conference communications Press releases

Government Affairs — State Issues:

NAME _____ TITLE _____

PHONE _____ E-MAIL _____

PCMA SmartBrief PCMA conference communications Press releases

Legal Issues Contact:

NAME _____ TITLE _____

PHONE _____ E-MAIL _____

PCMA SmartBrief PCMA conference communications Press releases

Medicare Contact:

NAME _____ TITLE _____

PHONE _____ E-MAIL _____

PCMA SmartBrief PCMA conference communications Press releases

Medicaid Contact:

NAME _____ TITLE _____

PHONE _____ E-MAIL _____

PCMA SmartBrief PCMA conference communications Press releases

Pharma Relations Contact:

NAME _____ TITLE _____

PHONE _____ E-MAIL _____

PCMA SmartBrief PCMA conference communications Press releases

Additional Pharma Relations Contact:

NAME _____ TITLE _____

PHONE _____ E-MAIL _____

PCMA SmartBrief PCMA conference communications Press releases

Additional Pharma Relations Contact:

NAME _____ TITLE _____

PHONE _____ E-MAIL _____

PCMA SmartBrief PCMA conference communications Press releases

Marketing Contact:

NAME _____ TITLE _____

PHONE _____ E-MAIL _____

PCMA SmartBrief PCMA conference communications Press releases

Communications/Public Relations Contact:

NAME _____ TITLE _____

PHONE _____ E-MAIL _____

PCMA SmartBrief PCMA conference communications Press releases

In submitting this membership application, the applicant agrees to the following:

- To support the purposes and activities of the Association, including its Legislative Principles.
- If admitted to membership, to pay annual dues as determined by the PCMA Board of Directors and to comply with the provisions of the PCMA Bylaws.
- On behalf of the applicant, the undersigned agrees to the foregoing conditions and certifies that the information in this application is true and correct.

SIGNATURE _____

DATE _____

NAME _____

TITLE _____

Please email completed application to:**Jenny Bradham**
jbradham@pcmanet.org**325 7th Street, NW, 9th Floor | Washington, DC 20004 | Phone 202.756.5700**