



## Application for Membership

\$20.00 Fellows  
\$10.00 Assoc Members  
\$10.00 Student Members

**Name:**

\_\_\_\_\_  
First M In. Last (Please Print)

**Home**

**Address:**

\_\_\_\_\_  
Street 1

\_\_\_\_\_  
Street 2

\_\_\_\_\_  
City State/Province Zip/Post Code

\_\_\_\_\_  
Country Phone

**License #**

\_\_\_\_\_

**Type Uc.** ( ) Pharm ( ) Vet

**Type of Membership**

**Position or Title**

**Institution**

**Address:**

\_\_\_\_\_  
Street 1

\_\_\_\_\_  
Street 2

\_\_\_\_\_  
City State/Province Zip/Post Code

\_\_\_\_\_  
Country Phone

**Email:**

\_\_\_\_\_

**Signature**

\_\_\_\_\_

Please send this application, with check or money order payable to the Society of Veterinary Hospital Pharmacists, to:  
SVHP Treasurer, Dinah Jordan, 605 Shadowood Lane, Starkville, MS 39759, mintjulep@cvm.msstate.edu