Pharmacy Health Information Technology Collaborative

Donation Form

Name of Organization: _____

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☐ Diamond: $50,000 ☐ Platinum: $20,000 ☐ Gold: $10,000

☐ Silver: $5,000 ☐ <$1000 (please specify)
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Name of Organization Contact: _____

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Indicate Donation Amount: _____

Checks should be made payable to "American Pharmacists Association", the organization with fiduciary responsibility for the Collaborative, with "Pharmacy HIT Collaborative" in the memo line. Mail completed membership form and check payments to:

Pharmacy HIT Collaboriative C/O American Pharmacists Association;
2215 Constitution Avenue NW; Washington DC 20037-2985; Phone 703-599-5051.
To request an electronic invoice please email your organization's name, complete mailing address and the name of contact person for invoicing purposes to Shelly@pharmacyhit.org