

# **2004 NAPPR Membership Application**

**DIRECTIONS:** Please print this form out. (Type or print legibly.) Submit this form along with your fees to the address below.

## **MEMBERSHIP FEES:**

\_\_\_\_\_ \$30.00 for Pharmaceutical Reps (*Full Membership*)  
\_\_\_\_\_ \$30.00 for Non-Pharmaceutical Reps (*Associate Membership*)

## **Please type or print the following information:**

Name \_\_\_\_\_  
Title \_\_\_\_\_  
Company/Org. \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
E-mail \_\_\_\_\_

## **MAIL MEMBERSHIP APPLICATIONS AND FEES TO:**

**NAPPR  
P.O. Box 161902  
Atlanta, Georgia 30321  
Phone: (770) 621-5746  
www.nappr.net**

*Please make checks payable to: NAPPR (credit cards not accepted)*