

**Membership Application**  
**National Council on Patient Information and Education (NCPIE)**

Please complete and return this form to NCPIE along with payment as noted below. For your convenience, payment may be made by check (payable to NCPIE) or credit card. Credit card payments may be faxed to (301) 340-3944 (or mailed to the address below). The NCPIE Membership Year is January 1 – December 31.

**My organization / company qualifies for the annual dues tier marked below:** *(Check One)*

1. \_\_\_\_\_ \$150 for public sector, consumer/patient advocacy groups, universities, state or regional managed care companies.
2. \_\_\_\_\_ \$750 for non-profit health professional organizations and trade organizations; and local/regional for-profit companies.
3. \_\_\_\_\_ \$7,500 for national and international for-profit companies.

**Check (✓) dues payment enclosed:**

1. \_\_\_\_\_ **\$150.00**
2. \_\_\_\_\_ **\$750.00**
3. \_\_\_\_\_ **\$7,500.00**

**Data for NCPIE Membership Record (please complete each item)**

Our NCPIE Member Contact will be:

Name/ Title: \_\_\_\_\_

Organization: \_\_\_\_\_ Website: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

**Complete only if paying by credit card:**

Expiration Date: \_\_\_/\_\_\_/\_\_\_

Visa     MasterCard #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

American Express #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**National Council on Patient Information and Education (NCPIE)**  
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