HIV Pharmacy Online Certification Training

FAX back to (509) 271-6579 to register for program OFFLINE

NAME

NAME OF PHARMACY

PHARMACY ADDRESS

PHARMACY PHONE NUMBER

PHARMACY FAX NUMBER

PHARMACY WEBSITE

NUMBER OF HIV PATIENTS CURRENTLY BEING SERVED

Payment Information:

1. Mail Check for **$1497.00** made out to **MichRx Pharmacist Consulting Services, Inc.**
   34145 Pacific Coast Hwy #211
   Dana Point, CA, 92629

2. Credit Card Information and authorization to bill $1497.00

   I authorize MichRx Pharmacist Consulting Services, Inc. to charge my credit card

   Company name:____

   Name on Card: ____

   Card Holder Phone # ____

   Cardholder email: ____

   Credit Card # ____

   Expiration Date: ____

   Security Code: ____

   Billing Address: ____

   City: ____

   Sate: ____

   Zip: ____

   Amount Charged: ____

Employee Information

NAMES AND EMAILS OF ALL PEOPLE TAKING THE TRAINING. PLEASE NOTE WHETHER THE INDIVIDUAL IS A PHARMACIST OR TECHNICIAN REQUIRING CEU'S

Name	Email	Pharmacist or Technician