Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

LABEL ORDER FORM

Please TYPE or PRINT. Include a **phone number** in case there is a question about your order.

*****IF YOU ARE A MEMBER OR ARE ORDERING FOR A MEMBER: BE SURE TO WRITE MEMBER PHYSICIAN'S FULL NAME SO WE CAN VERIFY THAT THEY ARE INDEED A CURRENT MEMBER. *****

Date____________________

MEMBER PHYSICIAN (IF APPLICABLE):____

NAME/COMPANY/FACILITY: ____

MAILING ADDRESS: ____

CITY: ________________________________ STATE: _______ ZIP: _______________

NAME & PHONE # OF PERSON PLACING ORDER: ________________________________

In the space below, please tell us exactly what information you would like in your order. **We *only* provide information for MD/DO's** however; we can break down by specialty, city, and a variety of other variables. Please specify if you'd like the labels in a particular order as well.

____

____

____

____

____

____

____

____

Price:

Member	$50.00
Non-Member	$100.00
P&H (if applies)	$9.00

Total Amt: __________

Please indicate payment below. **We now accept all major credit cards**

Check enclosed: #______________.

Card #_____________________________Exp. Date_________ CVS Code__________

Signature____

Billing Email Address:____

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

Electronic Information File Order Form

Please TYPE or PRINT NEATLY. Include a **phone number** in case there is a question about your order.

*****IF YOU ARE A MEMBER OR ARE ORDERING FOR A MEMBER: BE SURE TO WRITE MEMBER PHYSICIAN'S FULL NAME SO WE CAN VERIFY THAT THEY ARE INDEED A CURRENT MEMBER. *****

DATE:________________________

MEMBER PHYSICIAN (IF APPLICABLE):____

NAME/COMPANY/FACILITY: ____

MAILING ADDRESS: ____

CITY: ____ STATE: _______ ZIP: ______________

NAME & **PHONE # OF PERSON PLACING ORDER**: ____

COMPANY NAME & EMAIL ADDRESS OF PRINTING/MAILING SERVICES BEING USED:

____

Please sign the attached agreement. Your order **WILL NOT** be processed unless the agreement is signed! Your order will only be sent to the printer/mailer of your choice to ensure the list is destroyed after use. You will receive a list of names and cities the addresses will be sent to.

In the space below, please tell us exactly what information you would like in your file: i.e. addresses for all MDs/DOs statewide, or... a list of all MDs/DOs in Anchorage who specialize in Family Practice and Pediatrics..... **We ONLY provide information for MDs/DOs**.

____

____

____

____

____

____

Price:

Member	$75.00
Non-Member	$250.00

Total Amt: __________

Payment: Please indicate payment type below. We cannot bill for this service. Payment must be processed and accepted PRIOR to receiving your order. We accept all major credit cards.

Check enclosed: #_______________.

Card #_________________________________Exp. Date__________ CVS Code_________

Signature____

Billing Email address____

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

Below, please explain in detail the intended use of the electronic information file (EIF) that you will be purchasing from ASMA:

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

By signing below, you agree that the EIF that you are purchasing is for a **ONE TIME USE ONLY** for the purpose stated above and that the file will be **PERMANATELY DESTROYED** after said use.

____

Print

____

Sign Date