International Drug Information Center
Arnold & Marie Schwartz College of Pharmacy and Health Sciences
Long Island University

Community Pharmacy/Institutional Subscription Application

Community Pharmacy/Institution Name: ____

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Contact information

Salutation: □ **Dr.** □ **Mr.** □ **Ms.** □ **Other** ***(please specify)*** ________________________________

First Name: ___________________________ **Middle Name:** ______________________________

Last Name: ____

Title (e.g. MD, PharmD, RN, RPh): ____

Position: ____

Telephone: _________________________________ **Fax:** __________________________________

E-mail:____

Street Address: ____

City: _______________________________ **State/Province:** ______________ **Zip Code:** _______

Country: ____

Type of Practice:

□ **Community Pharmacy**
□ **Hospital**
Number of beds: □ **<100**
□ **100-299**
□ **300-499**
□ **500-699**
□ **700 or more**

□ **Long Term Care Facility**
Number of beds: □ **<100**
□ **100-299**

□ **300-499**
□ **500-699**
□ **700 or more**

□ **Group practice or clinic**
Number of physicians: ____

□ **Other** ***(please specify)*****: ____**

□ **Yes, we are interested in receiving the IDIC newsletter via e-mail**

□ **Yes, we are interested in receiving the IDIC newsletter via fax**

Mail the completed application along with a check payable to the ***International Drug Information Center*** **to the following address:**

International Drug Information Center
Arnold & Marie Schwartz College of Pharmacy and Health Sciences
75 DeKalb Avenue, Room HS 509
Brooklyn, NY 11201

Subscription will be activated upon receipt of payment. You will be mailed a certificate of enrollment along with an access code.