

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

Individual Subscription Application

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

First Name: _____ Middle Name: _____

Last Name: _____

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

Practice Type: _____

Street Address: _____

City: _____ State/Province: _____ Zip Code: _____

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Telephone: _____ Fax: _____

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Yes, I am interested in receiving the IDIC newsletter via e-mail

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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.
