

Order Form

Membership Mailing List



First Name		Last Name	
Title		Company	
Address 1		Suite	
City, State Zip		Email	
Phone		Fax	

Standard Rates – For MEMBER Address LIST All ACP Members Physicians and Allied Healthcare <i>(EMAILS are not provided)</i>	
Website Sponsors – Full List	\$1250.00 <input type="checkbox"/>
Non-Members or Non Website Sponsors – Full List	\$1500.00 <input type="checkbox"/>

<input type="checkbox"/> Custom List Rates - List Price is Per Record with a minimum of 300 records or \$600.00		
\$2.00 per record	X qty	= TOTAL
\$2.00		

If you choose a custom list, contact ACP to confirm list size at info@acpmail.org or 510.346.6800

Description of list: Ex. Physicians in NY, NJ and CT _____

Label Sequence Order (check one): Zip Code Alphabetical (member last name)

ORDER FORM CHECK LIST and AGREEMENT:

Complete the following and submit form with a copy of your mailing or description of mailing for pre-approval.

YES, I agree to the conditions of purchase, as outlined in the list rental agreement policy (Document # LRA0408).
The list received will be used **one time only** for the **ACP pre-approved mailing**.

Signature: _____ Date: _____

LIST RENTAL PAYMENT for ACP ACCOUNTING

Company		Contact Name	
_____ Check or _____ Credit Card Payment		TOTAL DUE	
Payable to ACP	Check #	Payment with Credit Card: <input type="checkbox"/> Visa <input type="checkbox"/> MC <input type="checkbox"/> AMEX <input type="checkbox"/> Discover	
Mail check: American College of Phlebology 101 Callan Ave. #210 San Leandro, CA 94577 Fax: cc info to: 510.346.6808 Email: cc info to lchreno@acpmail.org		Credit card #	Exp.
		Name on card	
		Billing Address	
		Security Code	
		Authorized by	

For office Use Only:

Received	Copy Approved	Processed	Confirmed	List Sent