



American College of  
PHLEBOLOGY

advancing vein care ▶

# MEMBERSHIP MAILING LIST Order Form

## Requester Information

The ACP Membership Mailing List is available to individuals or organizations who wish to promote an item or event that pertains to phlebology through a one-time mailing. Prior to filling this form out, please read the Mailing List Rental Policy.

First and Last Name: \_\_\_\_\_

Company: \_\_\_\_\_ Title: \_\_\_\_\_

Street Address: \_\_\_\_\_ Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Toll Free: \_\_\_\_\_

For ACP Member pricing, ACP Member ID: \_\_\_\_\_

## List Type & Pricing

### Standard Rates for the Entire ACP Membership Mailing List (Check One)

- ACP Individual Member **\$1,250.00**
- Organizations or Individual Non- Members **\$1,500.00**

### Customized Rates

A minimum order of 300 records is required. Final quantity will be determined by ACP Staff and an estimate to be provided to the requester based on the rate of \$2.00 per record.

- All Members in \_\_\_\_\_ (state/region)
- Domestic US Physicians in \_\_\_\_\_ (state/region)
- International Physicians in \_\_\_\_\_ (all/country)
- Allied (non-physician) Members in \_\_\_\_\_ (state/region)
- Other \_\_\_\_\_ (please describe)

### Delivery Details

All lists are delivered electronically

Label Sequence:  Zip Code Order  Alphabetical by last name  Other \_\_\_\_\_

### Agreement

- Yes, I have read and agree to the conditions of purchase as outlined in the list rental agreement policy posted on the ACP website. I understand that the list will be used one time only for the approved copy submitted to the ACP with this request. If the list is used for another purpose, I understand that I and/or my organization will be subject to additional charges.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Payment Information

Check Made Payable to AMERICAN COLLEGE OF PHLEBOLOGY Amount: \_\_\_\_\_

Credit Card:  MasterCard  Visa  American Express  Discover Expiration Date: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_ Security Code: \_\_\_\_\_

Name on Card: \_\_\_\_\_

For Office Use Only  
Received:

App & Copy Received

Approved by Staff

Approved by ED/BOD

Payment Processed

List Sent