

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • asma@asmadocs.org

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 be sent directly to a 3rd party printer/mailer of your choice to ensure the list is destroyed after use. You will receive a list of names and cities the addresses have been 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.....

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 _____

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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