MEMBERSHIP REGISTRATION FORM
(The membership fee is $25.00)

Name: ______________________________________________________________________________________

Title: ______________________________________________________________________________________

Company: __________________________________________________________________________________

Address: ____________________________________________________________________________________

City, State, Zip: _____________________________________________________________________________

Phone: ___________ FAX: ___________ E-mail: ____________________________________________________

☐ Please send me email updates regarding chapter events

My regulatory interests are (Check all that apply):

- FDA GLP
- Veterinary GCP
- Pharmaceutical GMP
- EPA GLP
- Human GCP
- Medical Device GMP

My occupation is oriented towards (Check all that apply):

- Human drugs, vaccines or devices
- Animal drugs, vaccines or devices
- Agricultural products (including pesticides)
- Contract Research Organization
- Educational Research Organization
- Innovator pharmaceutical, vaccine or device firm
- Generic pharmaceutical, vaccine or device firm

Professional Affiliations (Please list)

_________________________________________________________________________________________

I would consider future participation in the MWSQA as a (check all that apply)

- Meeting Attendee
- Meeting Presenter - List Topic(s)
- Elected Officer (preference?)
- Committee Member (preference?)

METHOD OF PAYMENT:

☐ Enclosed is my check made payable to MWSQA.

Remittance must be made in US dollars. A $10.00 surcharge may be assessed to cover any returned checks.

☐ Charge to the following credit card (circle one): MasterCard VISA AMEX

Card Number: ___________________________ Expiration Date: ___________ Security Code: ___________

Cardholder Signature: __________________________________________________________________________

Cardholder Name as it Appears on Card: _______________________________________________________________________

Credit Card Billing Address: _____________________________________________________________________________

PRINT COMPLETED FORM AND RETURN WITH FULL PAYMENT TO:
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Charlottesville, VA 22911 USA
Tel: 434.297.4772 Fax: 434.977.1856 Email: chapters@sqa.org