APHON

ASSOCIATION of PEDIATRIC HEMATOLOGY/ONCOLOGY NURSES

MAILING LABEL ORDER

The following guidelines apply when ordering labels:

- Duplication or reselling of labels is not permitted. Labels are sold for **one-time use only**.
- **A complete sample mailing piece must accompany all orders**.
- Pre-payment for all orders is required.
- Allow 10 working days from the date the sample mailing piece is received by APHON.
- All label orders are subject to approval.
- Labels will not be sold for promotion of meetings or courses occurring within one month (pre or post) of any APHON meeting/event.

Bill To:

Name_____

Company_____

Address_____

_____

City/State/Zip_____

Phone_____

Ship To:

Name_____

Company_____

Address_____

_____

City/State/Zip_____

Email _____

Label Type
- ☐ 4-Up Pressure Sensitive
- ☐ Disk (ASCII)
- ☐ Email _____ (Email address to send labels to)

Sequence
- ☐ Alpha Order
- ☐ Zip Code Order (Default)

Send Via
- ☐ UPS
- ☐ Fed-EX _____ (Provide Account#)

Selection Criteria
- ☐ Entire Membership (Approx. 3300)
- ☐ States (contact our office for specific counts)

List States_____

_____

Cost

☐ Entire Membership	$850.00
☐ Partial Listing (less than 1,000 names)	$475.00
☐ Disk Format Fee	$35
☐ Email Format Fee	$35
☐ Set-up & Shipping Fee	$20.00
Total	$_____

Member Practice Demographics

☐ Practice Setting
☐ Home Care ☐ Hospice
☐ Hospital Inpatient ☐ Hospital Outpatient
☐ Physician's Office ☐ School of Nursing

☐ Functional Area
☐ Direct Patient Care ☐ Education ☐ Research
☐ Administration ☐ Case Management

☐ Position
☐ Clinical Nurse Specialist ☐ Director/Ass. Dir
☐ Educator ☐ Nurse Manager
☐ Staff Nurse ☐ Supervisor

Payment Method

☐ MasterCard ☐ Visa ☐ American Express ☐ Check (enclosed check payable to APHON)

- If rebilling of a credit card charge is necessary, a $25 processing fee will be charged.
- I authorize APHON to charge my credit card in US Dollars for the amounts shown plus applicable shipping & handling.
- Checks not in US funds will be returned. A charge of $25 will apply to any check is returned for insufficient funds.

_____ _____

Account number Expiration date

_____ _____

Signature Cardholder's name (please print)

➢➢Complete & return this form along with payment & sample mailing piece≪≪

APHON Mailing Labels
8735 W. Higgins Road, Ste 300
Chicago, IL 60631
☎ 847/375-4724 Fax 847/375-6865

For office use only:

Client ID _____

Tracking Code _____

Date Shipped_____