



# MAILING LABEL ORDER

ASSOCIATION of PEDIATRIC  
HEMATOLOGY/ONCOLOGY NURSES

### 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. 2600)
- States (contact our office for specific counts)  
List States \_\_\_\_\_

**Cost**

- Entire Membership \$300.00
- Partial Listing (less than 1,000 names) \$175.00
- 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**  
**Attn: Kate Anderson**  
**4700 W Lake Ave**  
**Glenview IL 60025-1485**  
**☎ 847/375-4724 Fax 847/375-6478**

*For office use only:*

Client ID \_\_\_\_\_

Tracking Code \_\_\_\_\_

Date Shipped \_\_\_\_\_