



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. 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
4700 W Lake Ave
Glenview IL 60025-1485
☎ 847/375-4724 Fax 847/375-6865

For office use only:

Client ID _____

Tracking Code _____

Date Shipped _____