BeMedWise Program at NeedyMeds
2020 BeMedWise Supporter Application
(January 1 – December 31)

Please complete and return this application along with payment to: NeedyMeds, 50 Whittemore Street, PO Box 219 Gloucester, MA 01931. For your convenience, payment may be made by check (payable to BeMedWise) or credit card. Click here to view the BeMedWise Supporter Categories and Benefits.

Credit card payments will be accepted for Public Sector ($200) and Non-Profit HCP Organizations ($1,000) only and may be faxed to (206) 260-8850 (or emailed to Deborah.Davidson@needymeds.org /mailed to the address below). BeMedWise will send you an invoice for all categories $2,500 and above.

My organization / company qualifies for the annual dues tier marked below: (Check One)

1. ________ $15,000 CHAMPION
2. ________ $10,000 ALLY - Business operational ≥ 3 years
3. ________ $2,500 FRIEND - Healthcare provider & trade organizations; Business startups operational < 3 years
4. ________ $1,000 NON-PROFIT - Healthcare Professional Organizations
5. ________ $200 PUBLIC SECTOR - Consumer/patient advocacy groups, universities, national, local government agencies (includes non-profits whose primary membership or constituency are patients and caregivers, including disease or consumer advocacy organizations).

Data for Membership Record (please complete each item)

BeMedWise MEMBER CONTACT:

Name/Title: __________________________________________________________

Organization/Company: __________________________ Website: ______________

Address: ____________________________________________________________

City: __________________ State: ______________ Zip code: __________________

Phone: ( ) __________ Fax: ( ) __________ E-mail: _______________________

NeedyMeds Federal Tax ID: 46-3091990

Payment Method

_________ Check payable to BeMedWise (U.S. Dollars)

_________ Electronic Direct Deposit Contact Deborah.Davidson@needymeds.org to obtain bank routing information.

_________ Credit Card - Authorized Amount: $1,000 ________ $200 ________

_________ Visa _______ Mastercard _______ American Express _______ Discover

_________ Diner’s Club _______ JCB

Card #: __________________________ Fax: ( ) __________ E-mail: __________________

Expiration Date: ________/_______ Security Code: ______________

Authorized Signature: __________________________________________________ Date: __________________

Send payment to: BeMedWise, 50 Whittemore Street, PO Box 219 Gloucester, MA 01931

TEL: 978-281-6666 FAX: 206-260-8850 Website: BeMedWise.org

Questions contact: Deborah Davidson at deborah.davidson@needymeds.org