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

NeedyMeds BeMedWise
Patient Information and Education

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 # :_____-_____-_____-_____
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