



HOPA Mailing List/Label Request Form

Take advantage of the opportunity to reach the decision makers in hematology/oncology pharmacy in your next direct mail campaign. The following guidelines apply when ordering lists or labels:

- Duplication or reselling of labels or lists is not permitted.
- Labels and lists are rented for a **one-time use only**. Violations of this policy could result in denial of future requests. Pre-payment is required for all orders.
- A sample mailing piece **must** accompany all orders. All orders are subject to approval.
- HOPA reserves the right to refuse or accept any list rental order for any reason.
- Allow 7-10 working days from the date the sample mailing piece is received by HOPA.

HOPA will also sell membership labels for the purpose of sending surveys on behalf of external organizations. Requests must comply with the HOPA External Survey Policy and meet the following criteria:

- HOPA full/associate members, faculty, researchers and/or care providers are eligible to submit a survey to the HOPA membership.
- Student/Resident research projects are not eligible to submit surveys to HOPA members regardless of membership status.
- Industry, medical education companies, companies marketing on behalf of industry or any other commercial interest are not eligible to send surveys, regardless of membership status, and will only have access to survey HOPA membership as a participant in the HOPA Industry Relations Council.
- Acceptable topics for surveys include practice-based, clinical, or educational research. Unacceptable topics include product/device or marketing-based research.

If you are interested in ordering HOPA lists or labels, please select the appropriate sort and rate, and complete the requested mailing information.

Sort

- Alpha sequence
- Zip code sequence

Rate

- Full list - \$2500
- Up to 37 U.S. States - \$1875
- Up to 25 U.S. States - \$1250
- Up to 12 U.S. States - \$625

Company/organization name _____

Contact name _____

HOPA member? Yes No

Address _____

City, State Zip _____

Submitted by _____

Phone (_____) _____ Fax (_____) _____ Date _____



If you will be using the HOPA mailing list to distribute a survey, please answer the following questions along with providing a copy of the survey with this request form.

I attest that I am submitting this survey on my own behalf or on behalf of the organization listed above.

Yes No

Company/Organization Type

- Non Profit/For Profit Hospital or Health Care Provider
- Government Organization
- Group Medical Practice
- Health Care Association
- Community Organization
- School of Pharmacy
- Other (Please explain) _____

Please provide a brief description of your including, including the objective and how survey results will be used and distributed.

Payment: MasterCard VISA Discover American Express Check (made payable to HOPA)

Acct. Number _____ Exp. Date _____

Name (As it appears on credit card) _____

Authorized Signature _____

Return to: **Hematology/Oncology Pharmacy Association**
Attn: Member Services Group
8735 W. Higgins Road, Suite 300
Chicago, IL 60631
Phone: (877) 467-2791
Fax: (847) 375-6865

<i>For office use only</i>
Date order received _____
Labels ordered _____
Labels run _____
Total no. labels _____
Date shipped _____