2009 NCPA Foundation
Community Pharmacy Bone Marrow Drive

Photography Consent and Release Form

I, the undersigned, hereby authorize the National Community Pharmacists Association and those acting with its authority to photograph me for the *2009 NCPA Foundation Community Pharmacy Bone Marrow Drive*. I authorize the future use of any such photographic or electronic reproductions of me for any purpose including but not limited to, commercial promotion and education as may be deemed appropriate by the National Community Pharmacists Association and the NCPA Foundation. (I understand that I may be identifiable from such photographic or electronic reproductions.)

Agreed and accepted by:

Print Name: _____

E-mail or phone number: _____

Signature: _____

Date: _____

I am signing this form as an individual: Yes_____ No_____

I am signing this form as a representative of my pharmacy: Yes_____ No_____

Name of pharmacy: _____

Name of photographer: _____

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