



SUBSCRIPTION ORDER FORM

Date: _____

Name: _____

Company: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Email: _____

Mailing address for publication (if different from above):

Name: _____

Company: _____

Address: _____

City, State, Zip: _____

Subscription Begin Date: _____

Prices: Single Issue:	\$8.95
Annual Subscription Fee:	\$50 (US) \$65 (Foreign)
Subscription Agency Fee:	\$40.00 (US) \$50.00 (Foreign)

Please return order form and payment to: *South Dakota Medicine*
 PO Box 7406
 Sioux Falls, SD 57117-7406
 Fax: 605.274.3274 Email: ereiss@sdsma.org

Please direct any questions to: Elizabeth Reiss
 Staff Editor, *South Dakota Medicine*
 Phone: 605.336.1965 Fax: 605.274.3274
 E-mail: ereiss@sdsma.org

For office use only:

Received by: _____ Date: _____

Amount Paid: _____ Date Paid: _____