

# AHRMM Membership Application



Date: \_\_\_\_\_

To make sure that your membership application is processed correctly, please take the time to complete all applicable sections of this form and include it with your membership payment. Member applications may also be completed online at [www.ahrmm.org](http://www.ahrmm.org).

## Contact Information

Prefix: \_\_\_\_\_

First Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Last Name: \_\_\_\_\_

Suffix: \_\_\_\_\_

Designation(s): \_\_\_\_\_

Membership Status (select one):  New  Renewal

Membership #: \_\_\_\_\_

*NOTE: Renewing members, if you do not have your member number, please contact AHRMM at (312) 422-3840 or [ahrmm@aha.org](mailto:ahrmm@aha.org). Email requests will be fulfilled within 1 business day.*

## Work

Organization: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Country: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Extension: \_\_\_\_\_

Mobile: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

## Home

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Country: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Mobile: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Please send all future AHRMM communications to my primary address (please select one):

Work  Home

## Professional Profile

In order for AHRMM to continue serving its members to the best of its ability, please complete the following information.

- Type of organization. (please select one)
  - Hospital/Medical Center
  - Integrated Delivery Network (IDN)
  - Managed Care Organization
  - Group Purchasing Organization
  - Consulting Firm
  - Military/VA/Government
  - Distributor
  - Manufacturer
  - Other (specify): \_\_\_\_\_
- Level of responsibility. (please select one)
  - Executive (CEO, CFO, President, etc.)
  - Vice President
  - Director
  - Manager
  - Associate
  - Technician
  - Clinician
  - Assistant/Agent
  - Other (specify): \_\_\_\_\_
- The supply chain area where you work the most. (please select one)
  - Central Services
  - Clinical Resource Management
  - Corporate Offices/Health System Headquarters
  - Consulting
  - Contract Management
  - Finance
  - Information Technology
  - Logistics
  - Materials Management
  - Purchasing
  - Pharmacy
  - Support Services
  - Value Analysis
  - Other (specify): \_\_\_\_\_
- In what year did you begin your career in the healthcare supply chain field?  
\_\_\_\_\_

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5. If you work in a hospital/medical center or IDN, where is your buying influence? (please select all that apply)

- Administration
- Central Service
- Emergency
- Environmental Services
- Mailroom/Printing
- Medical/Surgical
- Operating Room
- Other (specify): \_\_\_\_\_

6. If you work in a hospital/medical center or IDN, what is your annual purchasing budget?

\_\_\_\_\_

7. In what setting is your facility located? (please select one)

- Rural
- Suburban
- Urban

8. What is the highest level of education you have completed? (please select one)

- High School
- Bachelors
- Masters
- Doctoral

9. How did you hear about AHRMM? (please select one)

- Advertising
- Annual Conference
- Direct Mail
- Local Chapter
- Member Referral
- Renewal
- Seminar
- Internet
- Other (specify): \_\_\_\_\_

Source Code (if applicable): \_\_\_\_\_

10. Do you belong to a local AHRMM Chapter? (please specify)

- Yes  No

Chapter Name: \_\_\_\_\_

Name: \_\_\_\_\_

## Dues and Payments

### Membership Dues

Please select from the appropriate membership category below for which you qualify.

- Supply Chain Provider (PROVIDER) .....\$110
- Active Duty Military (MI) .....\$110
- Affiliate/Supplier (SUPPLIER) .....\$160
- Supply Chain Executive (CEO) .....\$150
- Young Professional Associate (YPA) .....\$85
- Retiree\* .....\$75
- Full-Time Student\* .....\$75

\*Qualifying information required. Contact AHRMM directly to apply for Full-Time Student or Retiree membership.

### Payments

Total Amount Due: \_\_\_\_\_

- Please send me an email confirmation of my membership.

Payments must be included with all mailed and faxed Membership Applications. To process credit card payments, please include your signature on the signature line below.



**Fax:** Member application and credit card information to AHRMM at (312) 422-3609.

Type:  VISA  MasterCard  American Express

Credit Card #: \_\_\_\_\_ Expiration: \_\_\_\_\_

Name (as on card): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Mail:** Check/money order made payable to AHRMM with application:

**AHRMM/AHA**

Attn: Professional Membership Groups

P.O. Box 75315

Chicago, IL 60675-5315



**Web:** www.ahrmm.org. Online applications and payments are fast, easy, and accurate.

**Terms:** Membership dues are effective one year from the date the membership application is accepted and processed. Membership eligibility is subject to the provision of the Association for Healthcare Resource & Materials Management bylaws. An applicant may join directly online using the secure form or may complete the registration form and send it into AHRMM with their form of payment via regular mail or fax. Applicants may be admitted to membership at any time during the year upon paying annual dues. Under cycle billing procedures, dues will be billed again 12 months later, not on a calendar basis. The American Hospital Association may deposit the enclosed dues, remittance pending consideration of the application, and, in the event the application is not approved, the American Hospital Association will properly refund remittance. Remittance of dues must accompany the application. Members may cancel their membership at anytime, but dues will not be refunded nor is membership transferable.