

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.

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. 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.

1. 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): _____

2. Level of responsibility. (please select one)

- Executive (CEO, CFO, President, etc.)
- Vice President
- Director
- Manager
- Associate
- Technician
- Clinician
- Assistant/Agent
- Other (specify): _____

3. The supply chain area where you work. (select all that apply)

- 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): _____

4. How long have you been a professional in the healthcare supply chain field? (please select one)

- Less than 2 years
- 2 - 5 years
- 6 - 10 years
- 11 - 20 years
- 20 years or more

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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? (please select one)

- Less than \$1 million
 \$1 to \$5 million
 \$5 to \$10 million
 \$10 to \$25 million
 Over \$25 million

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: _____

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.

Name: _____

Dues and Payments

Membership Dues

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

- Employed by an AHA organization (REGAHA) \$100
 Active duty in the uniformed services (MI) \$100
 Employed by non-member organization (REGNON) . \$130
 Employed by the trade press (TPNON) \$130
 CEO of non-member institution (CEO) \$140
 Full-time student (STU) \$66

University Name: _____

University Phone: _____

Projected Graduation Date (month/year): _____

- Retiree (RT) \$66

Organization Name: _____

Organization Phone: _____

Date Retired (month/year): _____

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 (31401-3120):

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.