

# 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).

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.*

## Contact Information

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

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

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

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

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

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

## Work

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

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

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.

### About You

1. Gender:  Female  Male

2. Date of Birth: \_\_\_\_\_

3. Highest Level of Education Achieved:

- High school/GED  Bachelor's degree  
 Some college  Master's degree  
 Technical School  Doctoral degree  
 Associate degree  Other

4. Years Worked in Healthcare Supply Chain Profession:

- 0-1 years  6-10 years  More than 20 years  
 2-5 years  11-20 years

5. Level of Responsibility: (please select one)

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

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

Yes  No

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

### About Your Organization/Facility

7. Supply Chain Areas in which You Work:  
(please select all that apply)

- Central Services  
 Clinical Resource Management  
 Corporate Offices/Health System Headquarters  
 Consulting  
 Contract Management  
 Finance  
 Human Resources  
 Information Technology  
 Logistics  
 Materials Management  
 Purchasing  
 Pharmacy  
 Support Services  
 Value Analysis  
 Other

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8. Number of Employees in Department:

- |                                          |                                                  |
|------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> 1-10 employees  | <input type="checkbox"/> 76-100 employees        |
| <input type="checkbox"/> 11-25 employees | <input type="checkbox"/> 101-200 employees       |
| <input type="checkbox"/> 26-50 employees | <input type="checkbox"/> 201-300 employees       |
| <input type="checkbox"/> 51-75 employees | <input type="checkbox"/> More than 300 employees |

9. Annual Purchasing Budget:

- |                                              |                                                  |
|----------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Less than \$500,000 | <input type="checkbox"/> \$5-10 million          |
| <input type="checkbox"/> \$500,000 – \$1 M   | <input type="checkbox"/> \$10-25 million         |
| <input type="checkbox"/> \$1-2 million       | <input type="checkbox"/> \$25-50 million         |
| <input type="checkbox"/> \$2-3 million       | <input type="checkbox"/> \$50-100 million        |
| <input type="checkbox"/> \$3-4 million       | <input type="checkbox"/> \$100-500 million       |
| <input type="checkbox"/> \$4-5 million       | <input type="checkbox"/> More than \$500 million |

10. Areas of Buying Influence:

(please select all that apply)

- Administration
- Cardiology
- Central Service
- Diagnostic Imaging
- Emergency
- Environmental Services
- Facility Planning & Construction
- Mailroom/Printing
- Medical/Surgical
- Oncology
- Operating Room
- Physician Clinic
- Other

11. Organization Type: (please select one)

- Academic Institution
- Acute Care Facility
- Assisted Living Facility
- Consulting Firm
- Distributor
- Group Purchasing Organization (GPO)
- Hospital/Medical Center
- Integrated Delivery Network (IDN)
- Managed Care Organization
- Manufacturer
- Military/VA/Government
- Rehabilitation Center
- Vendor
- Other

**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 Charter and Governance Policies. 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: \_\_\_\_\_

12. Organization Setting: (please select one)

- National
- Rural
- Suburban
- Urban
- Other

13. Organization's Licensed Bed Count:

- |                                      |                                       |                                             |
|--------------------------------------|---------------------------------------|---------------------------------------------|
| <input type="checkbox"/> 1-25 beds   | <input type="checkbox"/> 101-300 beds | <input type="checkbox"/> 501-800 beds       |
| <input type="checkbox"/> 26-100 beds | <input type="checkbox"/> 301-500 beds | <input type="checkbox"/> More than 800 beds |

## Dues and Payments

### Membership Dues

Please select from the appropriate membership category below for which you qualify. Prices are valid 1/1/2019-12/31/2019.

- Supply Chain Provider (PROVIDER) ..... \$165
  - Active Duty Military (MI) ..... \$165
  - Affiliate/Supplier (AFFILIATE) ..... \$240
  - Supply Chain Executive (CEO) ..... \$220
- Young Professional Associate\* ..... \$135
- Full-Time Student\* ..... \$109
- Retiree\* ..... \$109

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

### Payments

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

- Please send me an email confirmation of my membership.



**Web: [www.ahrmm.org/Join](http://www.ahrmm.org/Join).** Online applications and payments are fast, easy, and accurate.

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

Type:  VISA  MasterCard  American Express

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

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

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



**Mail:** Check (made payable to AHRMM) with application **(31401-3120):**

**AHRMM/AHA**

Attn: Professional Membership Groups

P.O. Box 75315

Chicago, IL 60675-5315