AHRMM
Advancing Health Care through
Supply Chain Excellence

CQO:
The Health Care
Supply Chain

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.

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.

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
   - ☐ Some college
   - ☐ Technical School
   - ☐ Associate degree
   - ☐ Bachelor's degree
   - ☐ Master's degree
   - ☐ Doctoral degree
   - ☐ Other

4. Years Worked in Healthcare Supply Chain Profession:
   - ☐ 0-1 years
   - ☐ 2-5 years
   - ☐ 6-10 years
   - ☐ 11-20 years
   - ☐ More than 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:

- ☐ 1-10 employees
- ☐ 11-25 employees
- ☐ 26-50 employees
- ☐ 51-75 employees
- ☐ 76-100 employees
- ☐ 101-200 employees
- ☐ 201-300 employees
- ☐ More than 300 employees

9. Annual Purchasing Budget:

- ☐ Less than $500,000
- ☐ $500,000 — $1 M
- ☐ $1-2 million
- ☐ $2-3 million
- ☐ $3-4 million
- ☐ $4-5 million
- ☐ $5-10 million
- ☐ $10-25 million
- ☐ $25-50 million
- ☐ $50-100 million
- ☐ $100-500 million
- ☐ 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 Health Care 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:

- ☐ 1-25 beds
- ☐ 26-100 beds
- ☐ 101-300 beds
- ☐ 301-500 beds
- ☐ 501-800 beds
- ☐ More than 800 beds

Dues and Payments

Membership Dues

Please select from the appropriate membership category below for which you qualify. Prices are valid 1/1/2020–12/31/2020.

- ☐ 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. 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