KAHRMM MEMBERSHIP FORM (2016)

Kansas Association for Healthcare Resource and Materials Management

Allied with the Kansas Hospital Association

Active, voting memberships are available to persons professionally engaged in health care purchasing, resource or materials management; group purchasing organizations; as well as medical manufacturers, vendors or distributors. Membership may also be obtained by those professionals in other healthcare related settings not mentioned.

KAHRMM ____**$45.00** _____**$55.00 (after March 30, 2016)** **Renewal or New Member** (circle)

KAHRMM / AHRMM One-check option: AHRMM membership is not required for KAHRMM membership; however, as a service to our membership, KAHRMM will coordinate your AHRMM membership renewal payment. Select your KAHRMM and AHRMM membership options, and send one check to KAHRMM for the total amount. When your AHRMM membership is due to renew, send your AHRMM membership renewal notice / invoice to the KAHRMM Treasurer and your AHRMM dues will be paid.

Note: Due to the initial AHRMM membership questionnaire, new AHRMM applicants are encouraged to join on-line at the AHRMM website (www.AHRMM.org). After your first year of AHRMM membership is complete, use the One-check option to renew your AHRMM membership.

AHRMM Membership Categories (Select one category - see AHRMM website for membership category descriptions)

Supply Chain Provider____$125.00 Affiliate / Supplier____$180.00 Military____$125.00
Supply Chain Executive____$170.00 Young Professional Associate____$100.00
Full-time Student____$90.00 Retiree____$100.00

AHRMM FELLOW: Year Earned_____ AHRMM CMRP: Year Earned_____
Additional Certifications _____

TOTAL AMOUNT: _____ (total amount should include AHRMM dues if renewing AHRMM membership)

I hereby apply for membership in KAHRMM and/or AHRMM and certify that I meet the membership requirements.

Name: (please print) _____ **Title:** _____

Name of Hospital or Employer: _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Work Phone: _____ **Home Phone:** _____

Cell Phone: _____ **Fax Number:** _____

E-mail _____ **KHA District (if known)** _____

Applicant's Signature: _____ **Date Submitted**_____

Hospital Employee: Y / N **Healthcare Vendor: Y / N**

PLEASE MAKE CHECKS PAYABLE TO **KAHRMM**, AND MAIL TO:

Geary Community Hospital
Attn: Chrissy Fink, RN, CMRP
Materials Management
1102 St. Mary's Road
Junction City, KS 66441