KAHRMM
Kansas Association for Healthcare Resource & Materials Management

AHRMM DIAMOND CHAPTER 2023

Allied with the Kansas Hospital Association

2024 Membership Form

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 Membership Categories (Select one category) ☐ **$100** ☐ **2024 New Member $-0-** ☐ **Complete and Return Membership Form by 4-30-24 $-0-**

Please check: Renewal ☐ **New Member** ☐

KAHRMM is a chapter affiliate of AHRMM, and has been recognized as a diamond chapter, the highest designation, for 6 years straight.

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 Membership Chair 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 ☐ $165.00 Affiliate / Supplier ☐ $240.00 Military ☐ $165.00
Supply Chain Executive ☐ $220.00 Young Professional Associate ☐ $135.00
Full-time Student ☐ $109.00 Retiree ☐ $109.00

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: Yes ☐ **Healthcare Vendor: Yes** ☐

PLEASE COMPLETE THIS FORM AND MAIL WITH PAYMENT TO:

Lori Selzer
KAHRMM Membership Chair
2009 N Parkridge Ct
Wichita, KS 67212

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