Annual Membership Application Form

Last Name: _____

First Name: _____

Title: _____

Name of Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ E-mail: _____

Are you a member of AHRMM? ☐ Yes ☐ No

Type of membership I am applying for:

☐ Active:. $30

☐ Retired. $10

☐ Active Military. $10

☐ Vendor …….. . $175*

**Price includes one personal membership and logo displayed on website. Additional personal memberships are at the active rate. This is an annual support fee, not specific to conference support.*

Membership term runs for 12 months from September 1 – August 31.

I would be interested in serving on the following committees:

☐ Membership ☐ Communications ☐ Education ☐ Other_____

It is my desire to become a member of this association in order to advance my opportunities in the healthcare supply chain and to assist my fellow members in the pursuit of the association's objectives. I will strive to safe-guard my responsibilities to my employer and to the association by adhering to sound supply chain principles.

☐ Pay by paypal ☐ Pay by check

If paying by check, make payable to: Treasurer of MAHRMM

Mail to:
c/o Jason Londrigan
Hospital Purchasing Service
3275 N M-37 Highway
Middleville, MI 49333-0247