ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Membership Application

First Name

Middle Initial

Last Name

Degrees, Certificates, Professional Designations (20 characters max.)

Preferred email address

❑ Business address ❑ Home address

Preferred mailing address

❑ Business address ❑ Home address

Employment information

Title

Organization

Address

City State ZIP Code

Phone

Email

Home information

Address

City State ZIP Code

Phone

Email

Categories

Regular member:
Anyone who is actively involved or interested in health care risk management or whose primary job responsibility includes healthcare risk management.

Student member:
Anyone who is a full-time student registered at an institution of higher learning and not currently working in health care risk management. Students must submit photocopies, identification, or recent transcript verifying current status.

Dues

❑ $159 (regular)
❑ $99 (student)

Payment

Fax: Send form with credit card information to (312) 422-3609.

❑ Visa ❑ MasterCard ❑ American Express

Number Exp. date

Signature Date

Mail: Send check or money order to
ASHRM, P.O. Box 75315, Chicago, IL 60675-5315

Online: Visit www.ashrm.org

Questions? Call (312) 422-3980 or
email pmgmembership@aha.org