

**PHILADELPHIA AREA SOCIETY FOR HEALTHCARE RISK MANAGEMENT
(PASHRM)**




APPLICATION for MEMBERSHIP

***Please check as appropriate:** **New** Membership or **Renew** Membership (both require an application)

MEMBERSHIP YEAR _____

WHAT YEAR DID YOU JOIN PASHRM? _____

Please print (legibly) or type:

First Name:		List Group Members:
Last Name:		
Title:		
Organization:	<input type="checkbox"/> Group Member	
Street Address:		
City:		
State:		 DATE APPROVED FOR MEMBERSHIP
Zip Code:		
Phone Number:		
Fax Number:		
Email Address:		
Organization Website:		
Role: Organization and Responsibilities that are included in your job: CHECK ALL THAT APPLY	<input type="checkbox"/> Ambulatory Care Center <input type="checkbox"/> Hospital – General <input type="checkbox"/> Hospital – Psychiatric/Behavioral Health <input type="checkbox"/> Hospital – Rehabilitation <input type="checkbox"/> Hospital System – Corporate Office <input type="checkbox"/> HMO/Managed Care Organization <input type="checkbox"/> Insurance Company <input type="checkbox"/> Law Firm <input type="checkbox"/> Physician Practice <input type="checkbox"/> Risk Management Consultant <input type="checkbox"/> School/University <input type="checkbox"/> Skilled Nursing/Long-Term Care <input type="checkbox"/> Other:	<input type="checkbox"/> Risk Management <input type="checkbox"/> Risk Financing <input type="checkbox"/> Claims Management <input type="checkbox"/> Litigation <input type="checkbox"/> Worker’s Compensation <input type="checkbox"/> Corporate Compliance <input type="checkbox"/> Performance Improvement <input type="checkbox"/> Infection Control <input type="checkbox"/> Nursing Administration
Credential Codes: Degrees/Designations you hold: CHECK ALL THAT APPLY	<input type="checkbox"/> RN <input type="checkbox"/> MBA <input type="checkbox"/> JD <input type="checkbox"/> ARM <input type="checkbox"/> BA <input type="checkbox"/> MSA <input type="checkbox"/> PhD <input type="checkbox"/> CPHRM <input type="checkbox"/> BS <input type="checkbox"/> MSN <input type="checkbox"/> CPHQ <input type="checkbox"/> BHA <input type="checkbox"/> MHA <input type="checkbox"/> CPCU	<input type="checkbox"/> HIPAA <input type="checkbox"/> Safety/Patient Safety <input type="checkbox"/> Medical Staff Credentialing <input type="checkbox"/> Patient Relations <input type="checkbox"/> Medical Records <input type="checkbox"/> Other:
Organizations of which you are a member: CHECK ALL THAT APPLY	<input type="checkbox"/> ASHRM Year Joined _____ <input type="checkbox"/> CNOR <input type="checkbox"/> NAHQ <input type="checkbox"/> RIMS	<input type="checkbox"/> Pennsylvania Bar Association <input type="checkbox"/> New Jersey Bar Association <input type="checkbox"/> Delaware Bar Association <input type="checkbox"/> Other:

****Annual dues: \$50.00** Please make check payable to **PASHRM**. Send the **completed application** along with the **membership dues by February 28th** to: **PASHRM, Jay S. Stein, AVP, Corporate Risk Management, Mercy Health System, One West Elm Street, Conshohocken, PA 19428. Phone: (610) 567-6813**

NOTE: Annual open renewal period: November 1 to January 31

PLEASE TURN OVER →

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AREAS OF EXPERTISE:

List your special areas of expertise:			Are you willing to speak on this topic:
	1.		<input type="checkbox"/> Yes <input type="checkbox"/> No
	2.		<input type="checkbox"/> Yes <input type="checkbox"/> No
	3.		<input type="checkbox"/> Yes <input type="checkbox"/> No
	4.		<input type="checkbox"/> Yes <input type="checkbox"/> No
	5.		<input type="checkbox"/> Yes <input type="checkbox"/> No