PLEASE CHECK ONE: New Member Application Renewing Member Application

Please complete all applicable areas:

Voting (regular) Member $30 Vendor/Sponsor Member $50 Student Member $20

Full Name (last, first, middle initial) ____________________

Preferred "Nick" Name ____________________

Job Title ____________________

Department or Business Title ____________________

Facility Name ____________________

Business (hospital, surgery center, manufacturer, etc.) ____________________

Address ____________________

City, State & Zip Code ____________________

E-Mail Address ____________________

Telephone Number ____________________

Facsimile Number ____________________

Are you an IAHCSMM Member? Yes No

Department/Service Information:

Department Reports to Whom? ____________________

Number of FTEs? ____________________

Number of Staff Persons ____________________

Please circle (3) or write in as applicable, those services provided:

- Woven Textiles
- Medical Instrumentation
- Surgical Instrumentation
- Patient Medical Equipment Asset Tracking
- Patient Medical Equipment
- Surgical Case Cart
- Obstetric Case Cart
- Inventory Management
- Flexible Endoscopes
- Other: ____________________
- Other: ____________________
- Other: ____________________

Please circle High Level Disinfection and Sterilization Methods:

- Ethylene Oxide
- Gas Plasma
- Automated Endoscope (Steris, Medicator, ASP)
- Pasteurizer
- Liquid Chemical Solution
- Other: ____________________
- Other: ____________________
- Other: ____________________

Most significant challenges/issues you face:

____
____
____

Referred by: ____________________
(MHCSMA MEMBER)

Application & Payment Information:

Please enclose a bank check or money order in the amount shown above with your completed form to:

Minnesota Chapter of IAHCSMM
P.O. Box 9
Hopkins, MN 55343