

association of Illinois Patient Access Management



Membership Application

Applicant
Name:

Title: _____ Phone Number: _____

License/
Certification: _____ Email Address: _____

Healthcare Facility/
Company Name: _____

Street Address: _____

City, State, Zip: _____

By signing below I authorize aIPAM to list the above information in the aIPAM roster.

Signature: _____ Date: _____

Benefits of Membership include:

- ✓ Invitations to workshops
- ✓ aIPAM newsletter
- ✓ Eligible to vote & hold office
- ✓ Eligible to serve on committees
- ✓ Discounted aIPAM conference fees
- ✓ aIPAM Membership Directory
- ✓ Networking opportunities
- ✓ Annual meeting & cocktail reception

Interested in serving on a committee? Check the ones that interest you.

- Program
- Membership
- Newsletter
- Payer Updates
- Finance
- Technology
- Education
- Elections/Bylaws
(CHAA/CHAM exams)

aIPAM Annual Membership is \$50.

Please make your check payable to **aIPAM** and mail it with this application to:

aIPAM
PO Box 582
Lemont, IL 60439

Please direct your questions and comments to
Gladys Virella-Martinez, Membership Chair, at:
gladys.virella-martinez@advocatehealth.com
(630) 990-5634

Welcome to aIPAM—Illuminating Patient Access Management