Application for initial membership **Membership Year: January 1, 2025 – December 31, 2025**

Application for renewal of membership

Application for membership transfer

# PLEASE PRINT OR TYPE

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| Last Name | First Name | MI | Credentials |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Phone # Ext. | Fax # | Email Address |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | |  | | |
| Employer | | Job Title | | |
|  | | | | |
| Mailing Address | | | | |
|  | |  |  | |
| City | | State | Zip | |
|  | | | | |
| I REQUEST MEMBERSHIP IN THE FOLLOWING CATEGORY **Active Membership:** Active members shall consist of individuals actively involved in credentialing, privileging, practitioner, or provider organizations, and/or regulatory compliance in the healthcare industry. Active members shall pay their dues. They shall be eligible to vote and hold office as defined within these Bylaws.  **Associate Membership:** Associate members shall consist of former active members who no longer meet the criteria for active membership, individuals who support NAMSS, or full-time students enrolled in a health-related field. Associate members pay dues but are not eligible to vote or hold office; however, they may serve in an advisory position. | | | | |
|  | | | | |
|  | Signature | Date | |  |
|  | |  | | |

**Dues**: A prospective member who joins the Association shall pay the annual dues amount as follows for the current or upcoming year (January-December) accordingly (N/A for membership transfers):

Jan/Feb/Mar – 100% = $40.00  Jul/Aug/Sep – 50% = $20.00

Apr/May/Jun – 75% = $30.00  Oct/Nov/Dec – 25% = $10.00

**Payment:**

|  |  |
| --- | --- |
| **Check Payment - Return the completed**  **application and dues check to:**  **Payable to:** MTAMSS  **Mail to:**  Alyson Hoffman, MTAMSS Treasurer  301 W 7th Ave  Big Timber, MT 59011 | **PayPal, Debit Card, or Credit Card payment – Return the**  **completed application to the following address, making**  **sure your email is included; an invoice will be emailed to you shortly for payment:**  Alyson Hoffman, MTAMSS Treasurer  301 W 7th Ave  Big Timber, MT 59011  **OR** [AHoffman5@pmcmt.org](mailto:AHoffman5@pmcmt.org) |

**Questions:** Contact Dia Ferguson, MTAMSS President at <mailto:Dia.ferguson@livhc.org> or Alyson Hoffman, MTAMSS Treasurer at [AHoffman5@pmcmt.org](mailto:AHoffman5@pmcmt.org).

**NAMSS**: The Montana Association of Medical Staff Services (MTAMSS) recruits and processes its own membership and dues independently from the National Association Medical Staff Services (NAMSS). While NAMSS membership is not a condition of MTAMSS membership, it has its own benefits.

Are you a member of NAMSS?  Yes  No

If not, and if you are interested in joining, please look at NAMSS website, *www.namss.org*.

**PLEASE TAKE A MINUTE TO COMPLETE THIS QUESTIONNAIRE AND RETURN IT WITH YOUR APPLICATION.**

**Certification:**

|  |  |  |  |
| --- | --- | --- | --- |
| Are you a Certified Medical Staff Coordinator (CPMSM)? | Yes  No | If yes, year certified |  |
| Are you a Certified Provider Credentialing Specialist (CPCS)? | Yes  No | If yes, year certified |  |
| If not certified, do you plan to take a certification exam within the next year? | Yes  No |
| Would you be interested in joining a study group if one is formed? | Yes  No |
| Would you be interested in chairing a study group? | Yes  No |
| Would you be interested in assisting a study group with one topic? | Yes  No |
| Do you want your email to be included in the MTAMSS e-blast notices/questions? (See guidance policy) | Yes  No |

**Experience:**

How many years have you been working in medical

staff services or related activities?  Less than one year

1-2 years

3-5 years

6-10 years

10-20 years

more than 20 years

Type of health care entity employed in:  Acute med/surg hospital

Teaching hospital

Ambulatory surgery center

Skilled nursing facility

Managed Care / Health Plan

PPO

MSO

Psychiatric facility

Armed Forces (branch )

Credentialing verification organization

Insurance Company

Medical Group

Other (type )

Do you know someone in a health-related field who performs activities as outlined in the “Active” membership category that might benefit from MTAMSS membership? If so, please share their name(s) and we will send them an application for membership.

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|  |  | |  |
| Last Name | First Name | | MI |
|  | |  | |
| Employer | | Job Title | |
|  | | | |
| Mailing Address | | | |
|  | |  |  |
| City | | State | Zip |
|  | | | |
| Email Address | |  |  |