KAHRMM
Kansas Association for Healthcare Resource & Materials Management

Allied with the Kansas Hospital Association

# 2020 Scholarship Application

**Member Name:** _____

**Member Employer:** _____

**Home Street Address:** _____

**Home City, State, Zip:** _____

**Cell Phone: (____)_____-_____** **Work Phone: (____)_____-_____**

**Email Address:** **Work** _____

**Home** _____

**Scholarship Assistance Requested for:**

- ☐ **KAHRMM Summer Session (June)**
- ☐ **CPE (October)**
- ☐ **Other, please specify** _____

_____

**Requesting Tuition Cost of $**_____

**Have you already paid Tuition?** ☐ **Yes** ☐ **No**

**Are you a current AHRMM member?** ☐ **Yes** ☐ **No**

**Total Amount Requested** **$**_____

_____ _____

**Applicant's Signature** **Application Date**

***Upon completion, email to Mike Morgan, President, at mmorgan@mcphosp.com or fax to 620-241-5612.***

*******To be completed by KAHRMM President and Treasurer*******

☐ Approved ☐ Denied President's Signature: _____

Check Number: _____ Check Amount: $_____ Date: _____

Date Check Mailed: _____ Treasurer's Signature: _____