Kansas Association Medical Staff Services 2022-2023 Membership Application

Membership Information

*Full Name: ____ Title:_______________
Last *First* *M.I.*

*Degree/Certifications: ❒ BA/BS ❒ MBA ❒ CPCS ❒ CPMSM ❒ Other: (please list)_______________

*Work Address: ____
Street Address *City* *State* *Zip*

*Phone: *Email:

Direct Report: Title:

Address: ____
Street Address *City* *State* *Zip*

Phone: Email:

Other Information

EXPERIENCE: How many years have you been working in medical staff services or related activities?

❒ 0-4 years ❒ 5-14 years ❒ 15-25 years ❒ More than 26 years

***ENTITY TYPE (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)_______________ ❒ Credent. Verification Org. ❒ Insurance Company
❒ Medical Group ❒ Other ______________________________

ACCREDITING AGENCY:

❒ DNV ❒ Joint Commission ❒ CMS/State ❒ HFAP ❒ URAC ❒ NCQA ❒ Other/none_______________

***OTHER MEMBERSHIPS:**

Are you currently a member of NAMSS (National Association Medical Staff Services)? Yes_____No_______,
If No, and you are interested in joining NAMSS, please go to www.namss.org for information.

***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 If yes, when and which certification? ___________
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

EDUCATION:

Please list 2 of your highest educational needs that you would like to have addressed in an educational conference:

1. ____
2. ____

Dues and Signature

Annual Dues: $40.00, Make Payable to KAMSS,
Return application and check to the KAMSS Treasurer:
Stormont Vail Health, Attn: Amber Kennedy
Medical Staff Services
1500 SW 10th Ave, Topeka, KS 66604

Signature: ____ Date:_______________

Any questions? Please contact Amber at: (785) 354-6229 or via email: akennedy@stormontvail.org