



**WISCONSIN MEDICAL GROUP MANAGEMENT ASSOCIATION  
Membership Application/Dues Renewal Invoice**

**Name:** \_\_\_\_\_ **Organization:** \_\_\_\_\_  
**Title:** \_\_\_\_\_ **Address:** \_\_\_\_\_  
**Email:** \_\_\_\_\_ **City/State/ZIP:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

Clinic/Department Information			
Specialties Represented – Select all that Apply			Type of Medical Practice
<input type="checkbox"/> Addiction Medicine	<input type="checkbox"/> Geriatrics	<input type="checkbox"/> Pathology	<input type="checkbox"/> Single-specialty <input type="checkbox"/> Multi-specialty primary/specialty care <input type="checkbox"/> Multi-specialty care only <input type="checkbox"/> Multi-specialty primary care only <input type="checkbox"/> Not applicable
<input type="checkbox"/> Allergy and Immunology	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Pediatrics	
<input type="checkbox"/> Anesthesiology	<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Psychiatry	
<input type="checkbox"/> Cardiology	<input type="checkbox"/> Nephrology	<input type="checkbox"/> Plastic Surgery	
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Neurology	<input type="checkbox"/> Psychiatry	
<input type="checkbox"/> Ear, Nose & Throat	<input type="checkbox"/> Multi-specialty	<input type="checkbox"/> Pulmonology	
<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Obstetrics/Gynecology	<input type="checkbox"/> Radiology	
<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Oncology	<input type="checkbox"/> Rheumatology	
<input type="checkbox"/> Family Medicine w/o OB	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Surgery (General)	
<input type="checkbox"/> Family Medicine w/OB	<input type="checkbox"/> Orthopedics	<input type="checkbox"/> Urology	
<input type="checkbox"/> Gastroenterology	<input type="checkbox"/> Pain Management	<input type="checkbox"/> Other	

Individual Information	
Which of the following best describes your primary scope of responsibilities? <input type="checkbox"/> Business/Administration Staff <input type="checkbox"/> Human resources <input type="checkbox"/> Clinical staff <input type="checkbox"/> IT <input type="checkbox"/> Coding/compliance <input type="checkbox"/> Marketing <input type="checkbox"/> Contracting <input type="checkbox"/> Other <input type="checkbox"/> Front office staff	How many years have you been in Healthcare Management? _____

**Please select a membership category** .

- Regular Membership - \$175**  
Available to eligible individuals, who are accountable for a range of activities, outcomes or organization goals; who are charged with achieving those goals through others and who are responsible for operations and have management responsibilities.
- Student Membership - \$25**  
Available to those individuals regularly enrolled as a full-time student in an accredited degree program of health care administration or an equivalent.

**List School/Program:** \_\_\_\_\_

**Group Membership:**  
Choose how many accounts you would like in your group: Groups must consist of at least 4 members each and each member receives a \$50 discount! The maximum dues amount you pay per group is \$4,000. Email: [wmgma@wmgma.org](mailto:wmgma@wmgma.org) for more information.

<b>Total Dues: \$</b> _____	<b>Payment Method:</b> <input type="checkbox"/> <b>Check#</b> _____	<input type="checkbox"/> <b>Credit Card (Visa / MasterCard / Discover / AMEX)</b>
Card # _____	Expiration Date _____	Security Code _____
Name of Cardholder _____	Billing Address: _____	
Signature _____		

Contact WMGMA  
 Executive Director: Jean Thomas, CMPE  
 Email: [wmgma@wmgma.org](mailto:wmgma@wmgma.org)  
 Phone: 319-560-0435  
 FAX: 319-774-5661  
[www.wmgma.org](http://www.wmgma.org)

**Mail Application To:**  
 WMGMA Executive Director  
 9466 Deer Valley Dr  
 Cedar Rapids, IA 52411