Wisconsin Medical Group Management Association
AFFILIATE MEMBERSHIP APPLICATION

Company: _____ **Email:** _____

Rep Name: _____ **Phone:** _____

Address: _____ **Fax:** _____

City, State, ZIP _____ **Web Site:** _____

Rep 2 Name: _____ **Rep 3 Name:** _____

Rep 2 Email: _____ **Rep 3 Email:** _____

Please provide the following information which will be posted on the Affiliates and Partner page of the web site:

Type of Business:

- ☐ Accounting
- ☐ AR Management/Collections
- ☐ EHR
- ☐ Healthcare Consulting
- ☐ Marketing/Advertising
- ☐ Medical Billing
- ☐ Medical Professional Liability Insurance
- ☐ Other Insurance
- ☐ Planning/Design/Build
- ☐ Practice Management Software
- ☐ Recruiting/Executive Search Firms
- ☐ Technology Solutions
- ☐ Other Healthcare Related Services

Brief Description of Business:

Note: The dues year is January-December. **Dues are not prorated.**

☐ **Affiliate Membership - $375**
Affiliate membership status is appropriate for individuals and entities whose primary purpose is to provide services or products to group practice operations.

Total Enclosed: $_____

Payment Method:

☐ **Check #**_____

☐ **Credit Card (Visa / MasterCard / Discover / AMEX)**

Card # _____ Expiration Date_____ Security (CVV) Code_____

Name of Cardholder_____ Billing Address: _____

Signature_____

Return this form with payment to:
WMGMA • 563 Carter Court, Suite B • Kimberly, WI 54136
920-560-5621 • Fax: 920-882-3655
wmgma@badgerbay.co • www.wmgma.org