



WISCONSIN MEDICAL GROUP MANAGEMENT ASSOCIATION
Membership Application/Dues Renewal Invoice

Name: _____ Name of Health System: _____
 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	Year Started in Healthcare Management: _____

Please select a membership category Note: The dues year is January-December. **Dues are not prorated.**

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. [Click here](#) to complete the process on our website.

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