



## Wisconsin Medical Group Management Association 2010 MEMBERSHIP APPLICATION/DUES RENEWAL

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_  
**Clinic:** \_\_\_\_\_ **Email:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**City, State, ZIP:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

<b>Specialties Represented</b> <i>Please check</i>		
<input type="checkbox"/> Allergy and Immunology <input type="checkbox"/> Anesthesiology <input type="checkbox"/> Cardiology <input type="checkbox"/> Cardiovascular Surgery <input type="checkbox"/> Dermatology <input type="checkbox"/> Emergency Medicine <input type="checkbox"/> Endocrinology/Metabolism <input type="checkbox"/> Family Practice w/o OB <input type="checkbox"/> Family Practice w/OB <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Geriatrics <input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Internal Medicine <input type="checkbox"/> Mental Health <input type="checkbox"/> Multispecialty <input type="checkbox"/> Nephrology <input type="checkbox"/> Obstetrics/Gynecology <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Orthopedic Surgery <input type="checkbox"/> Otolaryngology <input type="checkbox"/> Pain Management <input type="checkbox"/> Pathology <input type="checkbox"/> Pediatrics	<input type="checkbox"/> Psychiatry (Physical Medicine & Rehab) <input type="checkbox"/> Pulmonary Disease <input type="checkbox"/> Radiology <input type="checkbox"/> Rheumatology <input type="checkbox"/> Specialty Undefined <input type="checkbox"/> Surgery (General) <input type="checkbox"/> Urology  <input type="checkbox"/> Other – My Specialty is not listed _____

<b>Please provide information on the following:</b>	
Years in your current position:	Number of medical doctors in your group:
Total years in Healthcare Management:	Are you using an electronic medical record? _____ No      _____ Yes
The following committees are looking for members. Please indicate which committee you would like to get involved with.  <input type="checkbox"/> Third Party Payer <input type="checkbox"/> Legislative <input type="checkbox"/> Education	If yes, indicate which one: _____

Non-discrimination: Membership in WMGMA shall not be withheld on the basis of age, gender, race, disability, or sexual orientation.

Please check a membership category. *Note: Dues year is January – December. Dues are not prorated.*

- Regular Membership - \$150.00/ year**  
 Eligibility for Regular Membership status is based on specific organization and individual criteria. An eligible individual is a leader within an ACO who is accountable for a range of activities, and who is responsible for operations and has management responsibility.
- Associate Membership - \$150.00 /year**  
 Allows managers of affiliated health organizations to attend meetings as a member and have access to other membership benefits. Associate members are not eligible to vote or hold office and may be restricted from certain membership meetings and mailings.

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

Please return this form with payment to:  
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 800-762-8968 • 920-560-5611 • Fax: 920-882-3655  
 lona@badgerbaymanagement.com • www.wmgma.org