

**Applications must be accompanied with:** 1) a sample of your group's letterhead, 2) an organizational chart that includes your position, and 3) dues payment.

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Group Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Group Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Birth Year: \_\_\_\_\_ Gender: \_\_\_\_\_ The first year you began your career in practice administration: \_\_\_\_\_

Number of licensed physicians in your group: \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time

■ Are you working 30 or more hours per week with this organization?  Yes  No Date hired in present capacity: \_\_\_\_\_

■ Are you directly responsible for the following?

- Human Resources  Physical Facilities  Patient Processing  Accounting  Data Processing  
 Public Relations  Quality Assurance  Other \_\_\_\_\_

■ Are you a member of National MGMA?  Yes  No

■ Are you a member of ACMPE?  Yes  No

If yes, which category applies to you?  Nominee  Certified  Fellow

**Please provide the name and signature of a group physician or immediate supervisor.**

Please print name & title: \_\_\_\_\_ Signature: \_\_\_\_\_

*I hereby certify that the above information is accurate and correct to the best of my knowledge, and that I have not willfully falsified any information to advance my eligibility status for membership in WSMGMA.*

Applicant signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE: Applications for membership will not be processed unless all information requested is completed, and the following enclosures are received:**

- A sample of your group letterhead
- An organizational chart showing your position (*may be hand-illustrated on your group letterhead*)
- Payment by check or credit card
- ✓ Return completed application, requested forms and payment to: **WSMGMA • 2033 6th Avenue, Suite 1100 • Seattle, WA 98121**  
(Applications with a credit card payment may be faxed to 206-441-5863)

■ **Annual dues are \$130. Dues payment may be prorated at \$10.85 per month.**

Enclosed is my check made payable to: **WSMGMA Dues** Amount Paid: \$ \_\_\_\_\_

Credit Card Payment (Visa or Mastercard Only).

Credit Card No: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_