

Washington State Medical Group Management Association Application for Membership

1. Membership category for which you are applying:

- Active Member** Serves in a management capacity more than 30 hrs/wk at a medical group, ambulatory health care organization, or multi-unit health system, with at least one MD/DO/DPM. **\$130 Annual Dues**
- Affiliate Member** Meets the same requirement as active but practice is located outside Washington State. **\$130 Annual Dues**
- Student Member** Full-time student enrolled in an accredited program of healthcare administration and not employed full-time. (Does not work in the business of selling services or supplies to medical groups, and does not otherwise qualify for Active or Affiliate membership.) **\$30 Annual Dues**
- Faculty Member** Holds a full-time faculty position teaching business or healthcare administration at an accredited college or university. **Dues Waived**

2. Name _____ Credentials (i.e. MBA, CPA) _____

Title _____

Group Name _____

Specialty 1) _____ 2) _____

Group Address _____

City _____ State _____ Zip _____

Telephone _____ Fax _____

E-mail _____ Group Web Site Address _____

Birth Year _____ Gender _____ The first year you began your career in practice administration _____

Number of licensed physicians (MD/DO/DPM) in your group (FTE) _____

Does your practice operate an Ambulatory Surgery Center? Yes No

Is your practice part of a Health Care Integrated Delivery System? Yes No

Do you work 30+ hours/week with this organization? Yes No Year hired in present capacity _____

Were you previously a member of WSMGMA? Yes No

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

Volunteer interests with WSMGMA: Membership Education Practice Tools Other _____

Please provide the name of a group physician or immediate supervisor along with title:

Print Name _____ Print Title _____

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 _____

3. Return completed application, requested forms and payment to:

(Applications with a credit card payment may be faxed to 206-441-5863)

WSMGMA
2033 6th Avenue, Ste 1100
Seattle, WA 98121

Active and Affiliate Dues payment may be prorated at \$10.85 per month from the month joining to the end of the year.

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

Credit Card Payment (Visa, Mastercard, AMEX Only).

CC #: _____ Exp. Date: _____

Billing Address of Cr. Card _____

Print Name: _____ Signature _____