



APPLICATION FOR MEMBERSHIP

Name (First, MI, Last): _____

Title/Position: _____ Year Appointed : _____

Employer / Group Name : _____

Business Address : _____

Business City : _____ State : _____ Zip Code (9-digit) : _____

E-Mail Address: _____

Business Phone: () _____ Business Fax: () _____

Type of Practice (Circle one): SS – single specialty MS – multi specialty Vendor/Consultant

Specialty (if single specialty) : _____ # of Physicians (full or part time) : _____ # of Employees (full or part time) : _____

MGMA Member? Yes No ACMPE Member? Yes No Status (Circle one): Fellow Certified Nominee

I am interested in participating in the following KMGMA committee(s) Insurance Rural Health Membership

Technology Legislative Is your practice a Rural Health Clinic? Yes No

Our EMR vendor is: _____ How long? _____ Practice Management Vendor? _____ How long? _____

I heard about KMGMA from current member Physician in our practice Other

Please explain: _____

MEMBERSHIP CATEGORIES;

Individual Membership: Must work in the medical field in the state of Kansas. Individual membership must be held by one who performs managerial duties in multiple areas, or performs administrative tasks in one area, or provides patient care and also performs significant managerial or administrative tasks or who is providing management consulting or billing services and who is not a collection agency. Must work in the healthcare field in the prevention, treatment and management of physical or mental illness located in a physician/provider's office, an inpatient and/or outpatient setting. An Individual member is entitled to all Association membership service, including the right to vote, to serve as an office of the association and to serve on any committee.

Allied Membership: May be held by one who is not eligible to be an Individual Member and who performs managerial duties in multiple areas, or performs administrative tasks in one area in an allied healthcare field, defined as; any of the diverse healthcare professions, including clinical laboratory, physical therapy, occupational therapy, dietetic services, medical records, speech-language, pathology, etc. It does not include dentists. Must be located in the State of Kansas. An allied member may not vote or serve as an officer of the Association and may not serve on committees or attend business meetings of the Association. Allied membership is not available to KMGMA Business Partners (Exhibitors).

Student Membership: A Student Member is an individual enrolled in a college level program leading to a degree in healthcare management; or a full time student who requests membership in the Association and does not qualify for any other membership category. A Student Member shall not be entitled to vote and is not eligible to serve as an officer in the Association.

Applicant Signature : _____ Date : _____

ANNUAL MEMBERSHIP RATES: Individual \$100.00; Allied \$200.00; Student \$25.00; Group 1-5 members \$400.00; 6-10 members \$750.00. Each individual must submit an application. Group membership must be submitted together.

Payment: Check payable to: KMGMA Credit Card: VISA MasterCard Discover
Credit Card Number Expiration
Cardholder Name CVV#
Billing Address
City State Zip
Signature Print Name as Signed

Please mail payment to: Claire Daniels, Executive Assistant; 5051 E. Lincoln #4C, Wichita, KS 67218 E-mail: cdaniels1@cox.net; 316-686-4414

Payment of dues entitles the member to state membership and access to member-only resources on the website www.kmgma.org. Membership will expire on December 31 unless renewed for the following year.

