Iowa Medical Group Management Association
Application for Membership
(New Member)

IMGMA's membership database is a vital link enabling us to network within the organization. Therefore, we ask you to please provide complete information. If you have any questions regarding completion of this application, please contact our Executive Director at (515) 280-6454 or send an Email to imgma@imgma.org.

PLEASE PRINT Today's Date_____

Last Name First MI (Nick Name)

Practice Name

Practice Address

City State Zip Code

Phone Number Fax Number E-mail Address

Your Job Title Your Direct Supervisor's Name and Title

Please Circle:

Membership Status Requested : Active Affiliate Allied Student

Education: HS Some College AA BS MA PhD Degree in_____

Are you a MGMA member? Y N ACPME Status: Non-member Nominee Certified Member Fellow

Your participation is extremely important for the success and accomplishments of our committees. Please indicate below the committee you would be interested in:

Legislation **Professional Development**

Marketing/Communications **Insurance/Reimbursement**

CLINIC CORPORATE STRUCTURE AND PROVIDERS:

TYPE OF PRACTICE:

Single Specialty___ Multi-Specialty___ Management Services Organization (MSO)_____

Other_____

Please select the KEY specialty that best describe your office:

Allergy	Internal medicine	Physical Medicine
Anesthesiology	Multi-Specialty	Podiatry
Cardiology	Neurology	Pathology
Consultant	Nephrology	Pulmonary
Dermatology	Obstetrics & Gynocology	Radiology
Diabetes	Occupational Medicine	Radiology-Therapeutic
Emergency Practice	Oncology	Rheumatology
Endovrinology	Ophthamology	Surgery-Cardiology
Ear/Nose/Throat	Orthopedic	Surgery-General
Family Practice	Otolaryngology	Surgery-Neurology
Gastroenterology	Psychiatry	Surgery-Plastic
Gynecology	Pediatrics	Surgery-Therapeutic
Hematology	Pediatric Cardiology	Urology
Health Service		

Total Number of M.D.'s / D.O.'s (in your office only) _____

Total number of Employees (At your Clinic location) _____
(Do not include Physicians)

Is your clinic part of a larger corporation / system? Y N

If yes, what is the name of the corporation / system:

_____

Is your corporation / system: For Profit Non-Profit

Annual Dues are $125.00

Please make your check payable to IMGMA and mail to:
IMGMA
100 East Grand Avenue, Box 118
Des Moines, Iowa 50309

Or

Credit Card Payment
Visa, Mastercard, Discover or American Express

Amount: $_____

Card Number:_____

Credit Card:_____

Card Expires:_____ _____Security Code: _____
MO YR

Print Card Holder's Name:_____

Signature:_____

Medical Group Management Association
MGMA
Iowa
A State Affiliate