

# APPLICATION FOR MEMBERSHIP



Wisconsin Medical Credit Association, Inc.  
PO Box 2005  
Fond du Lac, WI 54936-2005

Date of Application \_\_\_\_\_

Name of Hospital, doctor's office, clinic or other \_\_\_\_\_

\_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Phone \_\_\_\_\_

Contact Person \_\_\_\_\_

Title \_\_\_\_\_

Administrator/CEO \_\_\_\_\_

Controller or Financial Officer \_\_\_\_\_

If multi-hospital system, please list which facilities (s) you are enrolling

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Facility Fee (includes 1 free subscription to *"The Voice"*)

\_\_\_\_\_ X \$250 = \$ \_\_\_\_\_

Additional Subscriptions to *"The Voice"*

\_\_\_\_\_ X \$50 = \$ \_\_\_\_\_

**Total Due** \$ \_\_\_\_\_