



Wisconsin Medical Credit Association, Inc.
PO Box 1507
Waukesha, WI 53187

Date of Application _____

Name of facility _____

Address _____

City _____ State _____ Zip _____

Phone _____

Contact Person _____

Title _____

Email address _____

Administrator/CEO _____

Controller or Financial Officer _____

If multi-hospital system, please list which facilities you are enrolling:

Facility Fee

Single Healthcare System

_____ X \$250 = \$ _____

Multi Healthcare System

_____ X \$350 = \$ _____

Associate Member

_____ X \$250 = \$ _____

Total Due \$ _____