



## Charlotte Area Medical Group Management Association Membership Application

Date \_\_\_\_\_

Name \_\_\_\_\_ Designation \_\_\_\_\_

Job Title \_\_\_\_\_

Practice/Company Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_ Web \_\_\_\_\_

MGMA Membership Number \_\_\_\_\_ Referred by \_\_\_\_\_

Do not include me on the NCMGMA member listserv.

**Optional Contact Information (For legislative purposes only)**

Home \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Membership Information

*Dues will be prorated for new members beginning June - October.*

**Active Member Applicant** - (employed by a medical practice)

\$180.00 (State Dues - \$150, Chapter Dues - \$30)

Type of Medical Group  Single Specialty  Multi-Specialty  Other

Specialty \_\_\_\_\_

Number of Physicians in Group \_\_\_\_\_ Full time \_\_\_\_\_ Part time

Number of Staff in Group \_\_\_\_\_ Full time \_\_\_\_\_ Part time

### Method of Payment

Check  Visa  MasterCard  American Express  Discover

CC# \_\_\_\_\_ Exp. Date \_\_\_\_\_

CID number on front of card above CC# (AMEX) \_\_\_\_\_ Last 3 digits from number on back of card (VISA/MC) \_\_\_\_\_

Name on Card \_\_\_\_\_ Signature \_\_\_\_\_

Billing Address \_\_\_\_\_

### Mail application, along with payment to:

NCMGMA, 1300 Baxter St., Ste. 360, Charlotte, NC 28204 or fax, with credit card payment, to 704-365-3678.

### Questions?

Call 704-365-0565 or 1-800-753-MGMA (6462); or email [info@ncmgm.org](mailto:info@ncmgm.org).