

Personal Information for Membership Directory Only (optional)

Home Address : _____

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

Home Phone : (_____) _____ Spouse Full Name : _____

Other Information

MGMA Member? (Y/N) : _____ Where should mail be sent? (Work/Home) : _____

Are you a member of a certified rural health clinic? (Y/N) : _____

If possible, name two KMGMA members who know you : _____

Are you a previous member of KMGMA? (Y/N) : _____ If so, when? _____

Name of Practice : _____

Was your membership under a different name at that time? (Y/N) : _____

If so, what was the name? : _____

Where did you hear about KMGMA? :
_____ Another KMGMA member
_____ Advertising
_____ Physician in our Practice
_____ Other (Please explain) _____