

**WASHINGTON ASSOCIATION MEDICAL STAFF SERVICES (WAMSS)  
MEMBERSHIP APPLICATION**

- Application for initial membership  
 Application for renewal of membership

Membership Year is **JANUARY – DECEMBER, 2021**

**PLEASE PRINT OR TYPE**

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Last Name First Name MI

If after reviewing the WAMSS website roster there are no changes to your contact information, please check here

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Phone # Ext. Fax # Email Address

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Employer Job Title

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Mailing Address

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City State Zip

**I REQUEST MEMBERSHIP IN THE FOLLOWING CATEGORY**

- Active Membership:** Active members are those individuals having responsibility in medical staff or related activities (e.g. credentialing, quality, provider relations). Active members shall pay dues and have a vote and are encouraged to join the National Association Medical Staff Services (NAMSS).
- Affiliate Membership:** Affiliate members are those individuals interested in the overall goals and objectives of the Association. Affiliate members shall pay dues but shall not be eligible to vote or hold office.

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Signature

Date

**Dues:** Dues for this year are \$50.00. Please make checks payable to WAMSS.

**Return the completed application and dues check to:** **WAMSS**  
**C/O Barbi Donovan**  
**PO Box 218**  
**Snoqualmie, WA 98065**

**NAMSS:** The Washington Association Medical Staff Services (WAMSS) recruits and processes its own membership and dues independently from the National Association Medical Staff Services (NAMSS). While NAMSS membership is not a condition of WAMSS membership, it has its own benefits.

Are you a member of NAMSS?  Yes  No

If not, and if you are interested in joining, please look at NAMSS website, [www.namss.org](http://www.namss.org).

**PLEASE TAKE A MINUTE TO COMPLETE THIS QUESTIONNAIRE AND RETURN IT WITH YOUR APPLICATION.**

**Certification:**

- Are you a Certified Medical Staff Coordinator (CPMSM)?  Yes  No If yes, year certified \_\_\_\_\_
- Are you a Certified Provider Credentialing Specialist (CPCS)?  Yes  No If yes, year certified \_\_\_\_\_
- If not certified, do you plan to take a certification exam within the next year?  Yes  No \_\_\_\_\_
- Are you earned a Provider Enrollment Specialist Certificate (PESC)?  Yes  No If yes, year completed \_\_\_\_\_
- Would you be interested in joining a study group if one is formed?  Yes  No \_\_\_\_\_
- Would you be interested in chairing a study group?  Yes  No \_\_\_\_\_
- Would you be interested in assisting a study group with one topic?  Yes  No \_\_\_\_\_

**Experience:**

How many years have you been working in medical staff services or related activities?

- Less than one year
- 1-2 years
- 3-5 years
- 6-10 years
- 10-20 years
- more than 20 years

Type of health care entity employed in:

- Acute Med/Surg Hospital
- Teaching Hospital
- Ambulatory Surgery Center
- Skilled Nursing Facility
- Managed Care / Health Plan
- PPO
- MSO
- Psychiatric Facility
- Armed Forces (Branch \_\_\_\_\_)
- Credentialing Verification Organization
- Insurance Company
- Medical Group
- Provider Enrollment
- Other (Type \_\_\_\_\_)

Do you know someone in a health-related field who performs activities as outlined in the "Active" or "Affiliate" membership categories that might benefit from WAMSS membership? If so, please share their name(s) and we will send them an application for membership.

Last Name	First Name	MI
Employer		Job Title
Mailing Address		
City	State	Zip
Email Address		