WCCP

WORKERS' COMPENSATION
CLAIMS PROFESSIONALS

P.O. Box 128
Dade City, FL 33526
(800) 642-7774
Fax: (866) 616-1220
http://www.wccp.org
FEIN 65-0156279

Membership Application

Thank you for your interest in the **Association of Workers' Compensation Claims Professionals**. To join the Association, select the appropriate membership level, complete the application and payment form, and mail or fax to the above address. *Please* write legibly. *(**Note: This application may NOT be used for marketing professionals, vendors or service providers.)*

We encourage you to charge your membership Online! Just go to http://www.wccp.org

____ **Adjuster/Nurse Case Manager**
1 - 9 Memberships $49.00 each/year
*10 or more Memberships $44.00 each/year
*(*Only when all memberships are paid at one time.)*

____ **Associate Member**
$110.00 Membership each/year
(Non-Adjuster/RN Claims, Medical or Risk Professionals)

Name: _____ License #: _____ Compliance Date: ____
(Exactly as it appears on your license) *(Mo / Yr)*

Preferred Mailing Address: _____

City: _____ State: _____ Zip:_____

Employer: _____ Position: _____

Bus Address: _____ City: _____ State: ____ Zip:_____

Daytime Phone: _____ Ext: _____ Fax: _____

*Email Address *(please include)*: Business _____ Personal _____
*(*As a service to our members, WCCP will email special announcements, newsletters, notice of employment or career opportunities, case law updates, and other important information. Please include personal and/or business email address.)*

Payment must accompany application. Please choose from one of the following options:

____ ***Check*** *(please mail with application to the above address)*
____ ***Credit Card (Visa, MC, AmEx, Discover)*** *(please complete the Credit Card Authorization below and fax or mail with application to the above address or fax number)*

Charge Card Authorization

Name (As it appears on your card): _____

Billing Address for Card: _____
Street or P.O. Box City State Zip

Credit Card #: _____ Exp Date: _____ Security Code: _____

Signature: _____ Date: _____ **Email: _____
*(**For credit card charges, email address is mandatory. You'll receive an email receipt immediately upon processing**)*

(Note: NSF checks will be charged a $35.00 fee. See the WCCP website for more information on NSF and refund policy.)

OFFICE USE ONLY

Check#_____ CC___ Date_____ Personal - Employer Database___ YM___ File___