

WSPR MEMBERSHIP REQUEST FORM
(required fields are marked with *)

Name*

Title*

Hospital/Group/System*

Email*

Web

Phone*

Mobile Phone

Fax*

Address*

City*

State and Zip*

Service Area of Your Organization

Description of Your Organization

Residency Programs in Your Organization

What percent of time is devoted to Physician
Recruitment?

How many years of experience do you have?

Highest Educational Degree

Is a fee charged to recruited physicians? If yes,
Please explain structure.

Please email or fax to:

Membership & Marketing Committee Chair:

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Email:rlmunson@wisc.edu