



P.O. Box 46879
 Tampa, FL 33647
 (800) 642-7774
 Fax: (813) 632-9377
<http://www.wccp.org>
 FEIN 65-0156279

**WORKERS' COMPENSATION
 CLAIMS PROFESSIONALS**

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	