

**Wisconsin Society of Healthcare  
Human Resource Administration**



**Membership Application**

Be sure to include your job description or a summary of your job responsibilities with your Membership Application. *Please note: Membership is on an annual (Jan.-Dec.) basis and is payable each year, regardless of when an individual joins.*

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Name of Organization: \_\_\_\_\_

Street: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Area Code/Telephone: \_\_\_\_\_ Fax #: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Do you have any professional certification?

PHR  SPHR  CEBS  CCP  Other (please specify): \_\_\_\_\_

What other HR organizations do you belong to?

ASHHRA  SHRM  RWHC HR Roundtable

State / Local: \_\_\_\_\_ Other (please specify): \_\_\_\_\_

How long have you been in your current position? \_\_\_\_\_

Is your application for WSHHRA membership new, or a replacement for someone at your organization?

New  Replacement  If replacement, for whom? \_\_\_\_\_

**About your Organization** – Please indicate type of organization (check one) and number of employees:

- |   |                      |  |                      |
|---|----------------------|--|----------------------|
| <input type="checkbox"/> Clinic                   | # of employees _____ | <input type="checkbox"/> Long Term Care Facility | # of employees _____ |
| <input type="checkbox"/> Health Care Vendor       | # of employees _____ | <input type="checkbox"/> Other (please specify)  | # of employees _____ |
| <input type="checkbox"/> Home Health              | # of employees _____ |  |                      |
| <input type="checkbox"/> Hospital/Hospital System | # of employees _____ |  |                      |

For those functions HR has responsibility, indicate the number of employees within your department.

Benefits \_\_\_\_\_ Compensation \_\_\_\_\_ Employment/Recruitment \_\_\_\_\_ Labor Relations \_\_\_\_\_  
Occupational Health \_\_\_\_\_ Payroll \_\_\_\_\_ Safety/Security \_\_\_\_\_ Training/Development \_\_\_\_\_  
Others \_\_\_\_\_ **Total # of HR Employees** \_\_\_\_\_

Will you help plan a future conference?  Yes  No

Which committee(s)/initiative(s) would you be willing to work on?

Best Practices  Board Activities  By-Laws  Communication  Compensation   
HR Leadership  Legislative  Membership  Other: \_\_\_\_\_

Do you have any suggestions for conference topics, speakers, or locations? \_\_\_\_\_

Other Comments: \_\_\_\_\_

**I hereby apply for membership in the Wisconsin Society of Healthcare Human Resource Administration.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Include a check for \$100 payable to WSHHRA (\$50 is the annual membership fee & \$50 is a one-time initiation fee). The \$50 initiation fee is waived if the applicant works at an organization with a current WSHHRA member. Mail all materials to WSHHRA at the following address:*

**WSHHRA, W175 N11117 Stonewood Drive, Suite 204, Germantown, WI 53022**