



NNU Headquarters, 8630 Fenton Street, Suite 1100, Silver Spring, MD 20910 ■ www.nationalnursesunited.org
 Main: 510-273-2200 ■ Facsimile: 510-433-2790 ■ Email: Membership@nationalnursesunited.org

REGISTERED NURSE INFORMATION AND DUES/FEEs AUTHORIZATION FORM

Please print clearly to ensure the accuracy of your information. Thank you!

RN Information			
(NNU ID #--If available)	(Employee ID#)	(RN License Number)	
(Date of Birth)	F <input type="checkbox"/> M <input type="checkbox"/>	(Base Hourly Rate)	(SSN #)
Address/Contact Information			
(Last Name)	(First Name)	(Middle Name or Initial)	
(Home Address)	(City)	(State)	(Zip)
(Home Telephone)	(Cell Phone)	(Home Email Address)	
(Work Telephone)	(Work Fax)	(Work Email Address)	
Facility Information			
(Name of Your <u>Primary Facility</u> : this is the facility where you work the most hours)		(Hire Date)	
(City and State)		(Department/Unit)	
(Name of Your <u>Secondary Facility</u> , if applicable)		(Hire Date)	
(City and State)		(Department/Unit)	

Membership Application. Check here: To the Officers and Members of NNU (the "Union"), I hereby tender my application for membership in NNU. I understand that while I may be required to tender monthly fees to the Union, I am not required to apply for membership or be a member as a condition of employment and that this application for membership is voluntary. As a member, I agree to obey the Constitution of NNU and to support the principles of trade unionism, and I authorize NNU and/or its designated affiliate to act as my exclusive representative for collective bargaining.

Check-Off Authorization. Check here: I authorize my Employer to deduct from my wages and forward to the Union monthly membership dues or an agency service fee if I am not a member, as set forth in the collective bargaining agreement between the Employer and the Union and the Constitution of NNU. This authorization shall be irrevocable for one (1) year or until the termination of the collective bargaining agreement between my Employer and the Union, whichever occurs sooner. I agree that this authorization shall be automatically renewed for successive one (1) year periods unless I revoke by giving written notice to my Employer (to the attention of the Senior Vice President for Human Resources or designee) and the Union, postmarked within ten (10) calendar days preceding the annual anniversary of the date of this authorization or upon expiration of the collective bargaining agreement. I expressly agree that this authorization is independent of union membership and in recognition of the value of the representational services provided to me by the Union. It shall continue in full force and effect even if I resign my Union membership, unless properly revoked in the manner prescribed above.

Important Notice: I also understand that Union members have certain rights and privileges as set forth in the Constitution and in various Federal laws. Union membership dues and agency service fees may be tax deductible only in limited circumstances according to the restrictions imposed by the Internal Revenue Code.

(RN's signature)

(Date)

If you choose not to authorize payroll deduction, you must select an alternative payment method on the reverse. ☞☞☞



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ADDITIONAL METHODS OF PAYMENT FOR THOSE NOT CHOOSING AUTOMATIC PAYROLL DEDUCTION
Please select ONE payment type from the three additional options below.

1. Electronic Funds Transfer (EFT) (Monthly Automatic Deduction from your checking account.)

Please check here.

Please select transfer date: 5th or 15th

Electronic Funds Transfer: This is to authorize NNU to withdraw your monthly dues/fees from your checking account identified by the attached voided check. NNU is authorized to change the monthly amount in accordance with annual scheduled dues increases by giving the undersigned thirty (30) days written notice. The undersigned may cancel this authorization by sending written notice of cancellation (20) days prior to the deduction date as designated above. PLEASE INCLUDE A VOIDED CHECK IN ORDER TO INITIATE YOUR CHECKING ACCOUNT TRANSFERS.

(Your signature above authorizes EFT.)

(Date Signed)

Please attach a VOIDED CHECK TO THIS FORM if you have selected EFT as your method of payment.

2. Credit Card (Monthly)

Please check here.

Please select transfer date: 1st or 15th

(Name on Credit Card)

(Credit Card #)

(Expiration—Month/Year)

(Your signature above authorizes automatic billing to your credit card.)

(Date Signed)

3. Direct Billing (Monthly or annually. Annual payments are due in advance.)

Please check here.

Please select invoice period: Monthly or Annually

(Your signature above serves to request direct billing.)

(Date Signed)

Please notify us immediately of any changes to your billing address.)