ILLINOIS NURSES ASSOCIATION
MEMBERSHIP APPLICATION/ADVOCATE HEALTH

APPLICANT INFORMATION		
Name: (Last, First, MI)		
Current address:		
City:	State:	ZIP Code:
Personal Email:	Cell:	
Home Clinic Address:		
Select one: Full-Time Part-Time PRN	Job Title:	

PAYROLL DEDUCTION DUES SCHEDULE (PLEASE CIRCLE CHOICE)

	Annually		Monthly	
	Dues	**Dues+PAC**	**Dues**	**Dues+PAC**
Full (more than .6FTE)	$717.31	$742.31	$59.78	$61.86
Part-Time or PRN (.6FTE or Less)	$373.65	$398.65	$31.14	$33.22

A PAC donation helps to support your organization in State Legislature, the State of Illinois Executive Offices and Agencies of the State where legislation is passed and administered that effects unions, nursing, and healthcare.

PAYMENT INFORMATION

EFT	Please provide a voided check	
Credit Card	Card Holder Name	
	Card #	
	Exp date	CVV#

MONTHLY PAYMENT

This is to authorize monthly electronic payment to Illinois Nurses Association (INA). By signing on the line, I authorize INA to withdraw my monthly dues from my account.

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Payment Authorization Signature

INA will charge a $5.00 fee for any returned drafts or chargebacks.

This check off authorization and Agreement shall be irrevocable for a period of one year from the date of execution or until the termination date of the agreement between the Employer and INA, whichever occurs sooner, and from year to year thereafter, unless not less than (10) days and not more than (20) days prior to the end of any subsequent yearly period, I give the Employer and INA individually written notice by certified mail, of revocation bearing my signature thereto.

INA is authorized to deposit this authorization with any Employer under contract with INA and is further authorized to transfer this authorization to any other Employer with INA in the event that I should change employment. This authorization shall likewise be fully enforceable and effective in the event I leave employment with any employer under INA contract and at a later time re-obtain employment with that same employer or any other Employer under INA contract, regardless of the length of time between termination and reemployment.

Signature of Employee:

Name: (Print)

Please return completed application to:

Illinois Nurses Association
Fax 312-896-3920
Email: membership@illinoisnurses.com
910 W Van Buren St Ste 502
Chicago, IL 60607