



340 Turnpike Street • Canton, MA 02021 • www.massnurses.org

LABOR PROGRAM MEMBERSHIP APPLICATION

PERSONAL INFORMATION

Name: _____ RN or Professional License Number* _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Cell: _____

*This is for internal use only. You will be assigned a random membership ID number.

Employer: _____ Hourly Rate of Pay: \$ _____ Work Ph: _____ Ext: _____

Job Title: (RN, LIC. SW, PT, MD, etc.) _____

Date of Hire: _____

Degree (BS, AD, etc.): _____ Date: _____ Institution: _____

Advanced Degree (MA, Ph.D, etc.): _____ Date: _____ Institution: _____

Professional Preparation (RN, MD, LIC. SW, etc.): _____ Graduation Date: _____

LABOR PROGRAM MEMBERSHIP DUES/FEEs

The monthly amount of dues for MNA shall be two times the individual member's base hourly rate of pay (**excluding any differential or bonus**), with a minimum monthly rate determined by the average of all step one hourly rates, times two, of all MNA collective bargaining wage scales in effect as of January 1 of the applicable year and not greater than the maximum rate determined by the average of all step seven hourly rates, times two, of all MNA collective bargaining wage scales in effect as of January 1 of the applicable year. Such minimum and maximum rates shall not be less than the prior year and shall take effect as of July 1 of the applicable year.

Member local unit dues may apply and are not included in the schedules listed below (please see attached for local unit rates). If you are interested in payroll deduction or have any questions regarding membership, please call the MNA Division of Membership at 781-821-4625.

CATEGORY	ELIGIBILITY (PLEASE CHECK ONE)	DUES STRUCTURE
Full Membership	(Employed Full Time, Part-time or Per Diem) <input type="radio"/> Registered Nurse	monthly dues equal 2X base hourly rate w/ established min. & max. **
* Reduced Membership	<input type="radio"/> Full Time Student (Min 12 Credits) Documentation required <input type="radio"/> New Grad from basic nursing or health care professional program (Within 6 months of graduation) <input type="radio"/> Age 62 or over and not earning more then Social Security system allows.	monthly dues equal 50% of 2X base hourly rate w/ established min. & max. **
Agency Service Fee	<input type="radio"/> Non-member category; contract compliance only.	monthly dues equal 95% of 2X base hourly rate w/ established min. & max. **
Health Care Professionals	<input type="radio"/> Non-RN	annual dues equal \$585.00 for July 2010 through June 2011
* Special Membership	<input type="radio"/> Age 62 or over and not employed. <input type="radio"/> Totally disabled. Documentation required	annual dues equal \$195.00 for July 2010 through June 2011

* Available subject to verification

** 7/2010 - 6/2011 minimum = \$65, maximum = \$78

PAYMENT OPTIONS Paying your membership fees should be easy. That's why MNA has several payment plans available.

Payroll Deduction - Please send me a payroll deduction form (NOT available for Reduced Membership and Special Membership).

Annual Payment (Billed Annually)

- Personal Check:** Enclose a check made payable to the Massachusetts Nurses Association. *Please include Local Bargaining Unit dues in amount.*
- Credit Card:** Complete information on back.

Installment Plan (3 Payments Billed Annually)

- Personal Check:** Enclose a check made payable to the Massachusetts Nurses Association. *Please include Local Bargaining Unit dues in amount.*
- Credit Card:** Complete information on back.

Monthly Payment (Withdrawn monthly on the 15th)

- Electronic Funds Transfer:** Complete information on back and enclose return documents as requested.
- Credit Card:** Complete information on back.

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PAYMENT AUTHORIZATION Please complete information below:

Credit Card

Please charge my: Mastercard Visa American Express Discover

*I hereby authorize and request the Massachusetts Nurses Association (MNA) to effect payment for any amounts owing by me to the MNA as such amounts become due monthly by initiating debit entries to my account indicated below. I authorize and request the credit card company to accept any debit entries initiated by MNA to such account and to debit the same to such account without responsibility for the correctness thereof.****

Card Number: _____ Expiration Date: _____

Cardholder Signature: _____

Electronic Funds Transfer (EFT)

Please read this authorization, include required materials and sign:

*I hereby authorize and request the Massachusetts Nurses Association (MNA) to effect payment for any amounts owed by me to the MNA as such amounts become due by initiating debit entries to my account indicated below by the financial institution named below, hereinafter called "bank", and I authorize and request bank to accept any debit entries initiated by MNA to such account and to debit the same to such account without responsibility for correctness thereof.***

Please enclose a **blank, voided check** (no deposit slips please) or **savings deposit slip with account & routing number**

Bank Name: _____

***It is understood that I may terminate this agreement at any time by written notification to MNA. Such notification to MNA shall be effective only with respect to entries initiated by MNA after receipt of such notification and a reasonable opportunity to act on it

UNION DIRECT POLICIES

- Returns from banks or credit card companies for insufficient funds, refusal of payments, closed or changed accounts etc., will result in an administrative fee billed to the member directly.
- **It is the responsibility of each individual to notify MNA of changes in status, employment status, leave status, name, address, etc. within 30 days of the change, to assure proper credit and continuation of services. No refunds will be issued if the member fails to fulfill this requirement. Any changes which may result in refunds will be processed accordingly at the time of notification and will be retroactive, when appropriate, for a 30-day period only.**
- MNA dues and assessments are not deductible as charitable contributions for federal income tax purposes. It may, however, be possible to deduct a portion of dues payments as a business expense.

Please initial here: _____

VOLUNTARY DONATION

I elect to contribute toward the nursing scholarship/research program or toward legislative efforts:

- The Massachusetts Nurses Foundation, Inc.** is a non-profit organization established in 1981, whose mission is to support nurses through scholarships and research awards.

I would like to contribute: \$_____ monthly or a one time donation of \$_____ (Please make check payable to **MNF**).

- Massachusetts Nurses PAC** is the voluntary, non-profit, political action committee for the MNA whose mission is to further the political education of all nurses and health care professionals, and to raise funds/make contributions to political candidates who support nursing and health care related issues.

I would like to contribute: \$_____ monthly or a one time donation of \$_____ (Please make check payable to **Massachusetts Nurses PAC**).

MNA REGIONAL COUNCILS

Members are assigned to one of five Regional Councils in which the member resides within the State, or, in the case of an out-of-state resident, to a Regional Council in which the member works.

Signature Return completed form to MNA Division of Membership, 340 Turnpike Street, Canton, MA 02021.

I have read and agree to the information contained in this document.

Signature _____

Date _____

Office Use Only:

Charge Code: _____ Amount: _____

Cash: _____ Ck. #: _____ Ck. Date: _____

V/MC: _____

Initials: _____ Date: _____

