



Safe Limits
Save Lives



Massachusetts
Nurses
Association

ASSOCIATE MEMBERSHIP BENEFITS

Who is eligible to be an associate member?

- Any Registered Nurse who is not covered by an MNA collective bargaining agreement.

What benefits am I entitled to as an associate member?

- You will receive an MNA membership card.
- You will receive the *Massachusetts Nurse Advocate*.
- You can be appointed to any congress, committee, task force or Center for Ethics and Human Rights as a non-voting member.
- You can take advantage of the MNA's free CE programs.
- You will have access to all of the discounts available to full members.

What benefits/rights are **NOT** available to me as an associate member?

- You cannot run for an MNA office, serve as an officer, or vote on any MNA issues.

PERSONAL INFORMATION

Name: _____ RN or Professional License Number* _____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Cell: _____ Work: _____ Ext: _____

DOB: _____ Gender: _____ Ethnicity: _____ Country of Origin: _____

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

EMPLOYMENT INFORMATION

Employer: _____ Address: _____ City: _____ Zip: _____

Job Title: (RN) _____

Hours Scheduled/Week: _____ Work Status (*please check one*) Full time _____ Part Time _____ Per Diem _____ Retired _____

EDUCATION INFORMATION

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

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

Additional Degree: _____ Date: _____ Institution: _____ Subject: _____

Special Certification(s): _____

ASSOCIATE MEMBERSHIP DUES

Annual Payment	3 Installment Payment Plan	Monthly EFT or CC
\$240.00	\$80.00	\$20.00

Office use only:
MNA I.D. _____

over →

PAYMENT OPTIONS

Paying your membership fees should be easy. That's why MNA has several payment plans available. Simply choose one of the payment methods listed below—the option is yours!

Annual Payment (Billed Annually)

- Personal Check** (Please enclose a check made payable to the Massachusetts Nurses Association)
- Credit Card** (Please complete information below)

Installment Plan (3 Payments Billed Annually)

- Personal Check** (Please enclose a check made payable to the Massachusetts Nurses Association)
- Credit Card** (Please complete information below)

Monthly Payment (Withdrawn monthly on the 15th)

- Electronic Funds Transfer** (Please complete information below and enclose return documents requested)
- Credit Card** (Please complete information below)

PAYMENT AUTHORIZATION

Please complete information below:

Credit Card

Please charge my: Mastercard Visa American Express

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 _____

Monthly Electronic Funds Transfer (EFT)

Please read this authorization, include required materials & sign:

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 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.

Voluntary Donation

I elect to contribute toward 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**).

ASSOCIATE MEMBERSHIP 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.

Signature

I have read and agree to the policies, terms and conditions contained in this document.

Signature _____

Date _____

Office Use Only:

Charge Code: _____ Amount: _____

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

V/MC: _____

Initials: _____ Date: _____

MNA