LABOR PROGRAM MEMBERSHIP APPLICATION

Massachusetts Nurses Association

ESTABLISHED 1903

Revised June, 2024

340 Turnpike Street • Canton, MA 02021 • www.massnurses.org • Fax: 781-821-4445 • Email: membership@mnarn.org

MNA℠ Massachusetts Nurses Association

PERSONAL INFORMATION

Name:_____ RN or Professional License Number* _____

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

Home Telephone: _____ Cell: _____

Email address (non-work): _____

DOB: _____ Gender ID: _____ Ethnicity: _____Country of Origin: _____

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

EMPLOYMENT INFORMATION

Employer:_____ Department: (ICU, MedSurg, etc.) _____

Job Title: (RN, LIC. SW, PT, MD, etc.)_____ Hourly Rate of Pay: $ _____

Date of Hire: _____ Hours Scheduled/Week: _____ Per Diem? ❍ Yes

EDUCATION INFORMATION

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

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

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

Additional Degree: _____ Date: _____ Institution: _____Subject: _____

Special Certification(s): _____

Office use only:
MNA I.D. _____

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 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) ☐ Registered Nurse	**monthly dues equal 2X base hourly rate w/ established min. & max. ****
*** Reduced Membership**	☐ Full Time Student **(Min 12 Credits) Documentation required** ☐ New Grad from basic nursing or health care professional program **(Within 6 months of graduation)** ☐ Age 62 or over and not earning more than Social Security system allows.	**monthly dues equal 50% of 2X base hourly rate w/ established min. & max. ****
Agency Service Fee	☐ Non-member category; contract compliance only.	**monthly dues equal 95% of 2X base hourly rate w/ established min. & max. ****
Non-RN Health-Care Professionals	☐ Healthcare professionals without RN or advanced nursing degree	**annual dues equal $686.16**

* *Available subject to verification*

** **see MNA website or contact Division of Membership for minimum and maximum rate**

PAYMENT OPTIONS The first payment will be processed upon receipt.

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.

Monthly Payment (Withdrawn the week of the 15th)

Complete information on back under **Union Direct Policies** for either choice:

☐ **Electronic Funds Transfer**

☐ **Credit Card**

Installment Billed (3 months)

☐ **Electronic Funds Transfer**

☐ **Credit Card**

over →

Voluntary Donation

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

☐ **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**).

Union Direct Policies

- Authorized monthly deductions are processed upon receipt then on the week of the 15th each month.
- 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.
- ***Automatic deductions continue unless/until the individual expressly communicates directly to MNA (Canton office) and wish to discontinue automatic payment (Canton office 781-821-4625, or membership@massnurses.org).***
- **It is the responsibility of each individual to notify MNA (Canton office)** of changes in status, employment status, including resignations & terminations, 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 (currently 95% of full member dues are tax deductible).

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 checking/savings account or credit card indicated below, unless/until I communicate directly to MNA (Canton office) to discontinue.

Electronic Funds Transfer option

☐ Checking ☐ Savings

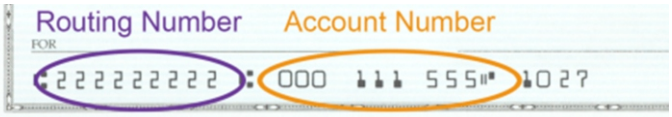
Name on account: _____

Bank name: _____

Bank routing #: _____

Account number: _____

Bank City/State: _____



Credit Card option

☐ Visa ☐ MasterCard

☐ Amex ☐ Discover

Cardholder name: _____

Credit card number: _____

Exp. date: _____ Security code: _____

First payment will be processed upon receipt.

Sign and return completed form to MNA Division of Membership, 340 Turnpike Street, Canton, MA 02021.

It is understood that this agreement will remain in place unless/until I expressly communicate to MNA (Canton office) that I wish to discontinue automatic payment. *It is further understood that I may terminate this agreement at any time by notification to MNA (Canton Office). Such notification to MNA shall be effective only with respect to entries initiated by MNA after acknowledged receipt of such notification and a reasonable opportunity to act on it. I have read and agree to the policies and terms and conditions contained in this document.*

Signature _____

Date _____

Office Use Only (Finance):
Check#: _____ Date: _____ Initial: _____
Total Paid: _____
Membership: Dues: _____ Fees: _____ Initial: _____
Credit: Approved: _____ Denied: _____ Date: _____