AUTHORIZATION FOR PAYROLL DEDUCTION

(PLEASE PRINT)

Name: _____ Practice Area / Unit: _____

Professional License #: _____ Employee #: _____

Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____

E-mail Address: _____ Fax #: _____

Area of Clinical Practice or Interest *(Check Two)*

- ❑ Administration
- ❑ ARNP
- ❑ Bioethics
- ❑ Child Health
- ❑ Chemical Dependency
- ❑ Computer Applications in Nursing
- ❑ Correctional Health
- ❑ Critical Care Nursing
- ❑ Gerontological Nursing
- ❑ Graduate Nurses
- ❑ Holistic Nurses
- ❑ Military/Federal Nursing
- ❑ Nurses in Home Health
- ❑ Nurse Educators
- ❑ Psychiatric/Mental Health
- ❑ Public Health
- ❑ Public Policy
- ❑ Research
- ❑ Retired Nurses
- ❑ Women's Health

I, _____
Full Name

direct **Eugene-Wuesthoff Memorial Hospital** to deduct from my bi-weekly pay, beginning with the pay for the first full pay period from the date this authorization is received by the Hospital, employee organization membership dues and uniform assessments, if any, of the Florida Nurses Association (FNA) in the amount as may be established from time to time in accordance with the Constitution and Bylaws of the FNA and certified in writing to the Hospital by an accredited officer, and direct the Hospital to pay over the sum or sums so deducted to a duly authorized representative of FNA. This authorization shall continue until (1) revoked by me at any time upon 30 days written notice to my employer and the employee organization, (2) the termination of my employment, or (3) my transfer, promotion or demotion out of this bargaining unit.

_____ _____
Date Employee Signature

FNA FLORIDA NURSES ASSOCIATION

Send yellow copy to:

FLORIDA NURSES ASSOCIATION
P.O. BOX 536985
ORLANDO, FL 32853-6985
(407) 896-3261; Fax (407) 896-9042

OPEIU WORK CONNECTS US ALL

WHITE COPY: EMPLOYER YELLOW COPY: FNA PINK COPY: EMPLOYEE