

UNITED FOR QUALITY HEALTH CARE

Health care works best when health care workers have a voice. By joining together in a union, SEIU Healthcare 1199NW members speak with a united voice for quality health care and good jobs. We work together to safeguard the delivery of quality care, improve the work environment in our facilities, and advocate for access to affordable health care for everyone.

You can do your part to advocate for quality care for our community by joining our union. Dues are 1.65 percent of your pay, with a cap of \$80/month.

To join, fill out the attached cards and mail them to the union office.



SEIU Healthcare 1199NW
15 S. Grady Way #200 Renton, WA 98057
www.seiu1199nw.org • 1-800-422-8934
fax: 425-917-9707

MEMBERSHIP APPLICATION



I support health care workers' effort to work together to advocate for quality health care and good careers. I accept membership in Service Employees International Union Healthcare 1199NW and authorize SEIU Healthcare 1199NW to represent me in collective bargaining with my employer.

Please Print

FIRST NAME _____ LAST NAME _____

HOME STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE NUMBER WITH AREA CODE _____

E-MAIL _____

HOSPITAL / CLINIC / AGENCY _____ DATE HIRED _____

DEPARTMENT/UNIT _____ SHIFT _____

JOB CLASS _____ SOCIAL SECURITY NUMBER _____

SIGNATURE _____ DATE _____

AUTHORIZATION FOR PAYROLL DEDUCTION

I, _____
(PRINT FIRST AND LAST NAME)

authorize _____
(EMPLOYER NAME)

to deduct from my wages and pay SEIU Healthcare 1199NW any initiation fee and dues or fees that I am responsible to pay to SEIU Healthcare 1199NW in order to secure and maintain my membership or comply with the terms of a union security provision of a collective bargaining unit. This authorization shall be irrevocable for a period of one year or until the termination of the collective bargaining agreement between my employer and SEIU Healthcare 1199NW, whichever occurs sooner. This authorization will be automatically renewed at the end of this period for successive periods of one year (or until the expiration of the collective bargaining agreement if that occurs sooner) unless I give my employer written notice revoking this authorization not more than 20 days and not less than 10 days prior to the end of each one-year period (or prior to the expiration of the collective bargaining agreement if that occurs sooner).

SIGNATURE _____ DATE _____

SOCIAL SECURITY NUMBER OR EMPLOYEE ID: _____