UNITED NURSES ASSOCIATIONS OF CALIFORNIA / UNION OF HEALTH CARE PROFESSIONALS, NUHHCE, AFSCME, AFL-CIO

VOLUNTARY DEDUCTION AUTHORIZATION

EMPLOYER
KAISER FOUNDATION
HOSPITAL AND HEALTH PLAN

AFFILIATE NO. 31-52
UNITED PHARMACISTS
OF SOUTHERN CALIFORNIA
(UPSC)

Pursuant to this Authorization and Assignment, the above-named Employer is requested to deduct from my pay, while I am employed within the collective bargaining unit of the Employer and irrespective of my membership status in the Union, a sum equal to the periodic dues, assessments, and/or fees, as designated by the Union. The Employer is requested to forward all sums promptly to the Union as designated above. The Union may advise the Employer from time to time of any changes to the said dues, assessments, and/or fees, and I request that the Employer immediately implement and deduct and forward the new sum(s) reflecting such change(s).

This Authorization and Assignment is voluntarily made in consideration for the cost of representation and collective bargaining, and is not contingent upon my present or future membership in the Union. This Authorization and Assignment shall remain in effect and shall be irrevocable unless I revoke it by sending written notice, with my signature, by U.S. mail or hand delivery to both the Employer and the Union no more than twenty (20) days and no less than ten (10) days immediately preceding the end of any yearly period subsequent to the date of this Authorization and Assignment or during the fifteen (15) day period immediately preceding the date of termination of the collective bargaining agreement in effect between the Employer and the Union, whichever occurs sooner, and shall be automatically renewed as an irrevocable check-off from year to year unless revoked as herein above provided.

Name (Print) ______________________ Professional Title ______________________

Address ____

City ______________________ State __________ Zip __________

SIGNATURE ______________________ Date ______________________

Employee Number ______________________ Date Hired ______________

– EMPLOYER COPY –

Do Not Detach Unless Reverse Side is Completed

UNITED NURSES ASSOCIATIONS OF CALIFORNIA / UNION OF HEALTH CARE PROFESSIONALS, NUHHCE, AFSCME, AFL-CIO

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Name (Print) ______________________ Professional Title ______________________

Address ____

City ______________________ State __________ Zip __________

SIGNATURE ______________________ Date ______________________

Employee Number ______________________ Date Hired ______________

– ASSOCIATION COPY –

EVERY FIELD MUST BE COMPLETED ON BOTH SIDES

NAME ____
(Please Print) (LAST) (FIRST) (M.I.)

UNITED NURSES ASSOCIATIONS OF CALIFORNIA / UNION OF HEALTH CARE PROFESSIONALS, NUHHCE, AFSCME, AFL-CIO

MEMBERSHIP APPLICATION

AFFILIATE NO. 31-52

**UNITED PHARMACISTS
OF SOUTHERN CALIFORNIA (UPSC)**

I hereby request and accept membership in the above named Affiliate of the United Nurses Associations of California/Union of Health Care Professionals, NUHHCE, AFSCME, AFL-CIO, and of my own free will do hereby authorize said Union its officers and representatives and agents, to act for me as a collective bargaining agency in all matters pertaining to rates of pay/wages, hours of employment, or other conditions of employment, and to enter into a labor agreement which may require the periodic dues and initiation fees uniformly required as a condition of acquiring or retaining membership.

Name (Print) ______________________ Professional Title ______________________

SIGNATURE ______________________ Last 4 digits SS# ______________________

Prof. License No. ______________________ Location & Unit/Dept. ______________________

STATUS: ☐ FT ☐ PT ☐ Per Diem/On Call

Cell Phone ( ) ______________________ Home Phone ( ) ______________________

Personal E-mail ______________________