



Montana Nurses Association ~ MEMBERSHIP APPLICATION

20 Old Montana State Highway • Clancy, MT 59634
• Phone 406-442-6710 • Fax (406) 442-1841 • www.mtnurses.org
Please mail or fax application to MNA Office

Date: _____

Last Name/First Name/M.I. _____

Mailing Address _____

City/State/Zip Code _____

() _____

Cell Phone _____

Personal E-mail Address _____

FOR MNA USE ONLY	
Facility Name	Process Date:
Date of Hire	District:
Employment Status (full-time/part-time/PDR)	Local Unit:
Date of initial RN licensure	Dues Amount:\$
Credentials(RN/APRN)	Pymt Type:
RN License #	Check # if Applicable
	<input type="checkbox"/> Collective Bargaining Member
	<input type="checkbox"/> Non-Collective Bargaining Member

MEMBERSHIP CATEGORIES Choose ONE Below
<p>*COLLECTIVE BARGAINING MEMBERS ONLY*</p> <p>If you choose to join and are a staff nurse employed at a facility that has a collective bargaining agreement with MNA you must select one of TWO options in this GREEN section:</p> <p><input type="checkbox"/> Collective Bargaining/Union Member ~ \$753.50 Annually</p> <p><input type="checkbox"/> Professional Reduced Rate - Collective Bargaining/Union ~ \$463.75 Annually <small>* New Grad - (1st year of membership only) Must apply within 6 months of obtaining initial RN licensure * RN in full time study towards a degree (up to 3 years) additional documentation required * RN 65+ years of age who is licensed</small></p> <p>*SIGNATURE REQUIRED BELOW*</p> <p><u>Revocation Window:</u> This voluntary authorization and assignment shall be irrevocable regardless of whether I am or remain a member of the Union, for a period of one year from the date of authorization, or until the expiration date of the collective bargaining agreement between the Union and the Employer, whichever occurs sooner, and shall automatically renew from year to year unless I revoke this authorization by sending written notice by the United State Postal Service to the MNA postmarked between August 1 and August 31 or by sending written notice by the United States Postal Service to the MNA upon expiration of the collective bargaining agreement</p> <p>Name (Printed): _____</p> <p>➔ Signature: _____</p>

MEMBERSHIP CATEGORIES Choose ONE Below
<p>*NON-COLLECTIVE BARGAINING MEMBERS ONLY*</p> <p><input type="checkbox"/> Non-Collective Bargaining/Non-Union Member ~ \$591.50 Annually</p> <p><input type="checkbox"/> Professional Reduced Rate - Non-Collective Bargaining/Non-Union ~ \$301.75 Annually <small>* New Grad - (1st year of membership only) Must apply within 6 months of obtaining initial RN licensure * RN in full time study towards a degree (up to 3 years) additional documentation required * RN 65+ years of age who is licensed</small></p> <p><input type="checkbox"/> Retired Member ~ \$156.88 Annually Date of Retirement _____ (62+ years of age and has ceased employment as a registered nurse)</p>

PAYMENT OPTIONS Choose ONE Below

1. Payroll Deduction Authorization:
NOT APPLICABLE FOR NON-FTE RN'S

Montana Nurses Association ~ AUTHORIZATION FOR PAYROLL DEDUCTION OF MEMBERSHIP DUES

• I, the undersigned, do hereby authorize _____ **Hospital/Clinic ~ Local Unit # _____**, to deduct sums equal to my membership dues, as certified by the Treasurer of the Montana Nurses Association Board of Directors, for the American Nurses Association and the Montana Nurses Association for the period of my employment and whether I am or remain a Union member. Deductions shall be in twelve equal installments from my earned or accrued wages. Money deducted is to be forwarded to the Montana Nurses Association for distribution to the three levels of the Association.

➔ Signature: _____

2. ANNUAL PAYMENT IN FULL (Enclose check payable to MNA)

3. CREDIT CARD PAYMENT – Monthly or Annually
A \$6 Annual (\$0.50 monthly) Service Fee will apply to all Electronic Payments

Monthly Annually

CARD #: _____

Expiration Date: ____/____/____

➔ Signature: _____

Credit Card Payment Authorization Signature

By signing on the line above, I authorize CMA/ANA to charge the credit card listed in the credit card information for the monthly or annual dues plus any additional service fees on the 1st day of the month per month or when annual renewal is due.

4. E-PAY
{MONTHLY ELECTRONIC CHECKING ACCOUNT FUNDS TRANSFER (EFT) }
A \$6 Annual (\$0.50 monthly) Service Fee will apply to all Electronic Payments

➔ Signature: _____

Monthly EFT Authorization Signature

By signing on the line above, I authorize my Constituent Member Association (CMA/ANA) to withdraw monthly electronic payments of 1/12 of my annual dues and any additional service fees from my account. Please enclose a void check. The account designated by the enclosed check will be drawn on or after the 15th of each month



*By signing the Electronic Deduction Authorization, or the Automatic Credit Card Payment Authorization, you are authorizing ANA to change the amount by giving the above-signed thirty (30) days written notice. Above-signed may cancel this authorization upon receipt by ANA of written notification of termination twenty (20) days prior to deduction date designated above. Membership will continue unless this notification is received. ANA will charge a \$5 fee for returned draft or chargeback. *State nurses association dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense. However, that percentage of dues used for lobbying by MNA is not deductible as a business expense. Please check with MNA for the correct amount.