

Please type or print clearly.

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Email \_\_\_\_\_

Last 4 Digits of Social Security Number \_\_\_\_\_

**Address has changed**

Use this form for information changes only.  
For any other changes to membership, contact our  
membership department.

**Return this completed form to:**

Washington State Nurses Association  
Membership Department  
575 Andover Park West, Suite 101  
Seattle WA 98188  
206-838-3099 *fax*

## Change of Dues / Status Category

I am: (circle one)

- A** Employed in a WSNA represented bargaining unit and working an average of 80 or more hours per month.
- B** Employed in a WSNA represented bargaining unit and working an average of 40 hours or more and less than 80 hours per month.
- C / D** Employed in a WSNA represented bargaining unit and working an average of less than 40 hours per month **or** Employed in a WSNA represented bargaining unit and working as a new graduate nurse who joins within 6 months of passing the NCLEX exam (reduced for the 1st year of membership only).
- E** 62 years of age and not employed **or** totally disabled.
- F** Employed an average of 80 hours or more per month and not covered by a WSNA collective bargaining contract.
- M** Employed, not covered by a WSNA collective bargaining unit working less than 80 hours per month **or** employed, not covered by a WSNA collective bargaining unit working as a new graduate nurse who joins within 6 months of passing NCLEX (for 1st year of membership only) **or** unemployed.

## LOA Taking an Unpaid Leave of Absence

Start Date \_\_\_\_\_ Anticipated End Date \_\_\_\_\_

## Change of Employer

Former Employer / Facility \_\_\_\_\_

Date Employment Terminated \_\_\_\_\_

Current Employer / Facility \_\_\_\_\_

Date Employment Began \_\_\_\_\_ FTE \_\_\_\_\_

Unit \_\_\_\_\_ Shift \_\_\_\_\_

## Change of Payment Method

**Full Annual Payment**

- Check enclosed**
- Visa / MC**

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_/\_\_\_\_\_  
Credit Card Number Exp. Date

**Installment Plan** 3 payments annually. \$3.99 annual charge. Enclose check for first installment payment with this form or enter payment information below.

- Check enclosed** You will be billed for future installments.
- Visa / MC** You will be automatically charged 3 times per year.

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_/\_\_\_\_\_  
Credit Card Number Exp. Date

**EFT - Electronic Funds Transfer** Include a voided blank check. This option authorizes a) monthly withdrawal of 1/12th of my annual dues; b) change of amount by giving the undersigned notice; c) cancellation of this authorization upon **written notification 20 days prior to the deduction date.**

**Payroll Deduction**

I hereby authorize my employer

to deduct my WSNA dues from my salary beginning with the next pay period. This money is in payment of dues to my professional association and is to be remitted to the Washington State Nurses Association. WSNA will send a copy of this authorization to be retained by the above named employer and will remain in force until **withdrawn by me in writing with 30 days prior notice to WSNA.**

## Signature

Signature \_\_\_\_\_ Date \_\_\_\_\_