



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	Employer Name ()	FOR MNA USE ONLY	
Last Name / First Name / Middle Initial	Work Phone Number	Process Date:	District:
Mailing Address	Date of Hire	Local Unit:	Dues Amount:\$
City / State / Zip Code ()	Employment Status (full-time, part-time, per diem)	Pymt Type:	Check # if Applicable
Phone Number	Graduation Date	<input type="checkbox"/> Collective Bargaining Member	<input type="checkbox"/> Non-Collective Bargaining Member
Personal E-mail Address (Please print clearly)	Credentials (RN/APRN)	RN License #	

MEMBERSHIP CATEGORIES Choose Only One	PAYMENT OPTIONS Choose Only One From the Four Options Below
<p>If you are a staff nurse employed at a facility that has a collective bargaining agreement with MNA you must join as a Collective Bargaining member.</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 * 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) * RN 65+ years of age who is licensed</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 * 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) * RN 65+ years of age who is licensed</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>	<p><input type="checkbox"/> 1. E-PAY {MONTHLY ELECTRONIC CHECKING ACCOUNT FUNDS TRANSFER (EFT) } A \$6 Annual (\$0.50 monthly) Service Fee will apply to all Electronic Payments</p> <p style="text-align: center;">Monthly EFT Authorization Signature</p> <p>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.</p> <p><input type="checkbox"/> 2. CREDIT CARD PAYMENT – Monthly or Annually A \$6 Annual (\$0.50 monthly) Service Fee will apply to all Electronic Payments</p> <p><input type="checkbox"/> Monthly <input type="checkbox"/> Annually</p> <p>Card #: _____</p> <p>Expiration Date: _____ Month Year</p> <p style="text-align: center;">Credit Card Payment Authorization Signature</p> <p>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.</p> <p><input type="checkbox"/> 3. ANNUAL PAYMENT IN FULL (Enclose check payable to MNA)</p>

4. Payroll Deduction Authorization: Please Complete Section Below.
 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 ~ District No. _____ 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, and as well as a nominal service charge to MNA.

• 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.

NAME (PRINTED): _____ DATE OF HIRE: _____

SIGNATURE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

*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.