

Change of Information Form

INSTRUCTIONS

- Please type or be sure to print very clearly.
- Complete the **name and address** section below, regardless of what type(s) of other changes you are requesting.
- To change your **dues category**, to tell us about a **leave of absence** or to switch to a new **payment method**, you only need to complete the section(s) that apply.
- To change your **employer of record**, do not use this form. Instead, complete a new membership application, which you can find online at www.wsna.org/membership.
- For any other changes, contact our membership department directly.

Contact Information

WSNA Membership Department
575 Andover Park West, Suite 101
Seattle, WA 98188

fax: 206-838-3099
phone: 206-575-7979
email: membership@wsna.org

NAME AND ADDRESS

Name _____

Address _____

City _____ State _____ Zip code _____

Home phone _____ Cell phone _____

Home email _____

Last four digits of Social Security number _____

Changes?

- Address has changed
- Name has changed

Former name _____

CHANGE OF DUES CATEGORY

- A** Employed in a WSNA represented bargaining unit and working an average of 80 or more hours per month. (0.5-1.0 FTE)
- B** Employed in a WSNA represented bargaining unit and working an average of 40 hours or more and less than 80 hours per month. (0.25-0.49 FTE)
- C/D** Employed in a WSNA represented bargaining unit and working an average of less than 40 hours per month (less than 0.24 FTE, or per diem), 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 and not covered by a WSNA collective bargaining contract, or unemployed.
- R** New graduate nurse, employed and not covered by a WSNA collective bargaining contract (for 1st year of membership only).

TAKING LEAVE OF ABSENCE

LOA start date _____

Date that my LOA changes to unpaid leave _____

Anticipated return to work date _____

NEW PAYMENT METHOD

Full Annual Payment

Payment is due during the first month of your annual billing cycle.

Check enclosed

Visa / MasterCard

_____ - _____ - _____
Credit card number

_____/_____
Expiration date

Electronic Funds Transfer (EFT)

Blank, voided check must be included

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

Only available for nurses represented by WSNA for collective bargaining.

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 _____