



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. 31-37

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 Association, 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.

Social Sec. No. _____ SIGNATURE _____ Date _____

Classification _____

Prof. License No. _____ Unit/Dept. _____

WORK AREA: Hospital Clinic SHIFT: Day Eve. Night
(WORK AREA)

STATUS: FT PT Res. Per Diem/On Call Date of Hire: _____ / _____
month year

Work Phone (_____) _____ Home Phone (_____) _____

Cell Phone (_____) _____ E-mail _____