

American Association of University Professors University of Connecticut Health Center Chapter

MEMBERSHIP AUTHORIZATION & DUES DEDUCTION AUTHORIZATION FORM

- 1) MEMBERSHIP AUTHORIZATION: YES! I want to join with my colleagues and become a member of UCHC-AAUP. I hereby request and voluntarily accept membership in UCHC-AAUP and I agree to abide by its Constitution and Bylaws. I authorize UCHC-AAUP to act as my exclusive representative in collective bargaining over wages, benefits, and other terms and conditions of employment with my employer.
- 2) DUES DEDUCTION AUTHORIZATION: I hereby request and voluntarily authorize my employer to deduct from my earnings and to pay to UCHC-AAUP an amount equal to the regular monthly dues applicable to members of UCHC-AAUP. This authorization shall remain in effect unless I revoke it by sending written notice to UCHC-AAUP within thirty calendar (30) days preceding the annual anniversary date of this agreement. This authorization shall be automatically renewed from year to year as long as I remain a member of the bargaining unit, unless I revoke it in writing during the 30-day window period.

SIGNATURE			DATE	
FIRST NAME			LAST NAME	
WORK E-MAIL A	DDRESS		"	
PERSONAL E-MAIL ADDRESS			CELL PHONE (optional)	
HOME ADDRESS				
CITY	(STATE/ZIP	
JCHC-AAUP Constituen	ncy (needed for ele	ections – check one)		
☐ medical/clinical	☐ dental	medical/basic science	Department	