ILLINOIS NURSES ASSOCIATION
MEMBERSHIP APPLICATION/ADVOCATE HEALTH

APPLICANT INFORMATION		
Name: (Last, First, MI)		
Current address:		
City:	State:	ZIP Code:
Email:	Home Phone:	
Current employer: **Advocate Health (403)**		
Employer address:		
Nursing Unit:	Work Email:	
Work Phone:	Work Fax:	
☐ FORMER MEMBER (YR) _____	☐ NEW MEMBER	

2017 PAYROLL DEDUCTION DUES SCHEDULE (PLEASE CIRCLE CHOICE)

	Annually		Monthly	
	Dues	**Dues +PAC**	**Dues**	**Dues+PAC**
Full (greater than .6FTE	$717.31	$742.31	$59.78	$61.86
Reduced(.6FTE or Less)	$373.65	$398.65	$31.14	$33.22

PAYMENT INFORMATION

EFT	Please provide a voided check	
Credit Card	Card Holder Name	
	Card #	
	Exp date	CVV#

MONTHLY PAYMENT

This is to authorize monthly electronic payment to Illinois Nurses Association (INA). By signing on the line, I authorize INA to withdraw my monthly dues from my account.

_____ *SEE BELOW

Payment Authorization Signature

*By signing the Automatic Monthly Payment Authorization, you are authorizing INA to change the amount by giving the undersigned thirty (30) days advance written notice. Membership will continue unless this notification is received. INA/ANA will charge a $5.00 fee for any returned drafts or chargebacks.

Signature of Employee:

Name: (Print)

"While membership dues are not deductible as charitable contributions for tax purposes, they may be deductible under other provisions of the Internal Revenue Code. "

A copy of our PAC report is available for purchase from the State Board of Elections in Springfield, Illinois.

INSTRUCTIONS:

PLEASE FAX COMPLETED APPLICATION TO 312-896-3920 IF YOU NEED ASSISTANCE, OR HAVE QUESTIONS, PLEASE CALL THE INA MEMBERSHIP DEPARTMENT AT 312-419-2900 Ext 243. WE WILL BE HAPPY TO ASSIST YOU.

RETURN COMPLETED APPLICATION FORM TO: Illinois Nurses Association
910 W Van Buren Suite 502
Chicago, IL 60607
FAX: 1-312-896-3920

REV 7.14.17