3510 Snouffer Road, Columbus, Ohio 43235
FAX 614-969-3888 614-969-3800 ● www.ohnurses.org
An equal opportunity and affirmative action organization ● ONA dues are nonrefundable

2024 APPLICATION FOR STANDARD MEMBERSHIP

OHIO STATE UNIVERSITY HOSPITAL

_____ _____ ___ _____ X X X - X X-_____
Last Name | First Name | MI | Degrees | Last 4 of Social Security No.

_____ _____ _____
Street Address | City, State and Zip | County

(_____)_____ (_____)_____ _____
Home Phone | Cell Phone | Home Email

(_____)_____ (_____)_____ _____
Work Phone | Work Fax | Work Email

OHIO STATE UNIVERSITY HOSP-COLUMBUS, OH _____ ____/____/____ (__) Yes (__) No ___/___/_____
Employer | Emp ID # | Barg. Unit Hire Date | US Citizen? | Date of Birth

MEMBERSHIP AUTHORIZATION & DUES DEDUCTION/CHECKOFF AUTHORIZATION FORM

MEMBERSHIP AUTHORIZATION: YES, I want to join with my colleagues and become a member of the Ohio Nurses Association (ONA), AFT, AFL-CIO. I hereby request and voluntarily accept membership in ONA and I agree to abide by its Constitution and Bylaws. I authorize ONA to act as my exclusive representative in collective bargaining over wages, benefits, and other terms and conditions of employment with my employer. I wish to have my dues collected through the following mechanism:

SELECT PAYMENT PLAN

$25.00 fee for returned checks

(__) Annual Payment – Enclose check payable to Ohio Nurses Association. Credit card for annual payment only.

- **Annual Rate**: **$937.10**

_____ _____/_____ _____
Visa / MasterCard / Discover | Exp Date | Signature

(__) Electronic Dues Payment Plan (EDPP) – Monthly payments will be deducted via ACH from your checking or savings account. Sign authorization below and fill in your routing and account number.

- **Monthly Rate: $78.59** (includes $0.50 monthly service fee)

AUTHORIZATION to provide monthly electronic payments to Ohio Nurses Association (ONA): This is to authorize ONA to withdraw monthly dues payments via ACH on or after the 15th day of each month from my checking or savings account. ONA is authorized to change the amount by giving the undersigned thirty (30) days notice. The undersigned may cancel this authorization upon receipt by ONA of written notification of termination twenty (20) days prior to the deduction date as designated above. ONA will charge a $15.00 fee for any returned drafts.

Signature for EDPP Authorization _____ Rtg# _____Acct# _____

(__) Payroll Deduction – I hereby request and voluntarily authorize my employer to deduct from my earnings and to pay over to ONA an amount equal to the regular monthly dues uniformly applicable to members of ONA.

- **Monthly Rate: $81.09** (includes $3 monthly service fee)

_____ _____ _____
Signature | Date | Employee Hire Date

One dollar ($1.00) per month of your dues goes to an account set up to support ONA's political efforts. You may choose at anytime to opt out of this dues designation. Opting out does not reduce the dues amount. If you are interested in opting out, please contact the Director of Governmental Relations & Political Advocacy at 614/365-9000. Payment plan option can only be changed during December 1st thru December 31st. If you have questions please contact the Membership Department at support@ohnurses.org.