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 ADDRESS _____

PERSONAL E-MAIL ADDRESS _____ **CELL PHONE (optional)** _____

HOME ADDRESS _____

CITY _____ **STATE/ZIP** _____

UCHC-AAUP Constituency (needed for elections – check one)

☐ medical/clinical ☐ dental ☐ medical/basic science Department _____

270 Farmington Avenue, Suite 364, Farmington, CT 06032
Telephone: 860-678-0826 Facsimile: 860-678-0832 Email: uchcaaup12@gmail.com