DUES CHECK OFF AUTHORIZATION/MEMBERSHIP AUTHORIZATION **(PRIVATE SECTOR)**

TO: ______________________________________ My Employer is authorized and directed to deduct from my wages or salary my weekly, bi-weekly or monthly dues each and every such period and to remit the amounts deducted to Doctors Council SEIU, 50 Broadway, 11th Floor, Suite 1101, New York, NY, 10004, as provided for in the Collective Bargaining Agreement between Doctors Council SEIU and my Employer. This authorization shall be irrevocable for the period of one year or until the expiration of the Agreement between Doctors Council SEIU and my Employer, whichever occurs sooner, and shall renew itself from year to year unless I give written notice to Doctors Council SEIU at least fifteen (15) days prior to the effective date of the revocation of this authorization. I hereby accept membership in Doctors Council SEIU and I authorize its agents and representatives to act as my exclusive collective bargaining agent in all matters pertaining to rates of pay, hours and other terms and conditions of employment. This full power and authority to act for the undersigned supercedes and cancels any power or authority heretofore given to any person or organization to represent me. I agree to abide and be bound by the union's constitution and bylaws and by any agreements or contracts that may be in existence at this time or that may be negotiated or agreed to by the union. This authorization shall be binding on any successor Employer, who is authorized and directed as stated above.

DATE: ______________________ Male or Female?______________________

Your Name (Please print)____________________________________(Please sign)______________________________________

Social Security Number(will be kept confidential)______________________________Date of Hire__________Date of Birth_________

Home Phone____Cell Phone______________________________

Home Pager (beeper)____Home Fax Number _________________________

Home Address____

City _____________________________________ State_________ Zip________________________________

Home e-mail address ____

Employer ____ Job Title _________________________________

Department/Unit/Work Location________________________Shift_________Number hours work per week ______Days off ___________

Status (circle one) Full Time Part Time Moonlighter Per Diem Sessional Other (please specify)_________________________

Work Phone____ Work Fax Number _________________________

Work e-mail address ____

What area(s) are you Board Certified in? ________________________________ Specialty area(s) ___________________________

What professional associations/societies do you belong to? ____

Other healthcare facilities or hospitals you work at ____

Medical School Attended _________________________________Residency Program/Hospital_____________________________

Are you a registered voter (circle one) Yes No Marital Status (circle one) Single Married Other Number of Dependents _________

Barry Liebowitz, M.D., President • email: info@doctorscouncil.com http://www.doctorscouncil.com
50 Broadway, 11th Floor, Suite 1101, New York, NY 10004 • Phone (212) 532-7690 • Fax (212) 481-4137
Affiliated with the Service Employees International Union (SEIU)