BCFPHN Membership Application
And Dues Deduction Authorization

Patricia Branum, President

Name:		SSN#: xxx-xx- ___ ___ ___ ___	
Home Address:	City:	State:	Zip:
Home Email:	Home Phone:		
Work **Check One:**	○ Public Health Nurse	○ Nurse Practitioner	
Bureau:	Program:	Work Extension:	
Location: (i.e., building, clinic, floor . . .)			
Hours **Check One:**	___ FULL Member **(> 25 hours per week)**: $ 20.25 Biweekly Dues		
	___ HALF Member **(≤ 25 hours per week)**: $ 12.25 Biweekly Dues		

I hereby apply for membership in the Baltimore County Federation of Public Health Nurses (BCFPHN) and authorize Baltimore County to biweekly deduct from my wages the amount certified by BCFPHN as my regular dues, accordance with the BCFPHN Constitution and By-Laws. This amount shall be paid to the Baltimore County Federation of Public Health Nurses. This authorization to deduct dues shall remain in effect until I cancel it in writing delivered to BCFPHN.

_____

Employee Signature **Date**

Email application to:

Vice President Beverly Grace, RN

Email bgrace@baltimorecountymd.gov

Revised 01/05/2024