BCFPHN Membership Application
And Dues Deduction Authorization

Name:	Employee ID:		
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.

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Employee Signature **Date**

Email application to: **Vice President** Beverly Grace, RN

Email bgrace@baltimorecountymd.gov

Revised 01/05/2024