Manitoba Association of HEALTH CARE Professionals

APPLICATION FOR MEMBERSHIP

I understand that the Manitoba Association of Health Care Professionals is the Union which will be representing me at my workplace. I wish to have my application for membership in MAHCP considered. If accepted, I will conform to and abide by the Constitution and Bylaws governing MAHCP. I have been informed of the regular membership dues of the Association and the manner in which they are determined.

DUES ARE 1.25% OF GROSS

PLEASE PRINT:

Name: _____

Home Address: _____

City/Town: _____ Postal Code: _____

Employer: _____ Site: _____

Department: _____ Occupation: _____

Classification: _____ Phone - Work: _____

Phone - Home: _____ Email - Home/Personal: _____

FULL TIME ❑ PART-TIME ❑ CASUAL ❑ TERM/TEMP ❑

Signature of Applicant: _____ Date: _____

Witness or Staff Rep: _____

MANITOBA ASSOCIATION OF HEALTH CARE PROFESSIONALS
101-1500 Notre Dame Ave., WINNIPEG MB R3E 0P9
1-204-772-0425; 1-800-315-3331

UNION LABEL LOCAL