



International Association of Workforce Professionals

IAWP Membership Application

Print or type information below and mail to Joseph Allen at 2320 Catalina Circle, Apt # 325, Oceanside, CA 92056.

Name: _____ Date: _____
Last, First, MI

SSN#: _____ Chapter: _____

Address: _____
Number and Street Address City State Zip Code

Telephone Number: _____ Home email address: _____

Job Title: _____ Date of Birth: _____ Male or Female: _____

Employer: _____

EDD Office Name & ARU # : _____ Bargaining Unit: _____
If applicable

Recruiter's Name: _____ Recruiter's Chapter: _____

IAWP Membership Dues

Membership Dues for the year after receipt of reimbursement from the state are as follows:

State Exempt Employees: \$0.00	State Employees Barg Unit 1, 2 and 4:	\$40.00
Non - State Employees: \$90.00	Retirees: \$32.00	

State Employees Only

If you wish to have your membership dues automatically deducted from your paycheck each month please sign the authorization below. The amount of **\$3.33** will be deducted from your monthly payroll check.

I hereby authorize the state controller to deduct from my salary and transmit as designated an amount for membership dues and any benefit program from which I have applied which is sponsored by the above employee organization, agency or credit union. This authorization will remain in effect until cancelled by myself or by the organization, agency, or credit union. I certify I am a member of the above organization, agency or credit union and understand that termination of membership will cancel all deductions made under this authorization.

Signed _____ Dated _____