

University of Wisconsin House Staff Association
Membership Statement and Authorization of Dues Deduction

My signature below signifies my desire to be a member of the University of Wisconsin House Staff Association (UWHA). I hereby authorize the University of Wisconsin Hospital and Clinics Authority or the University of Wisconsin-Madison to deduct from my monthly salary check the amount of \$3.00 for payment to UWHA.

Name (Please Print): _____

Hospital ID #: _____ Social Security #: _____

Signature: _____ Date: _____

Please return this form to UWHA / PO Box 45373 / Madison, WI 53744