FORM A

MEDICAL LABORATORY PROFESSIONAL WORKERS' UNION (MELPWU)

MEMBERSHIP ENROLMENT FORM

PART I: PERSONAL DETAILS:

1. Name (Surname first): …….…… Title: …...……
2. Date of Birth …… /..…. /……Age: …… Gender: ……..... Nationality: …….……
3. Home Town: ……..…. Region: ……. District: …….
4. Marital Status: ……. Number of Children: …… (if applicable)

PART II: EMPLOYMENT DETAILS:

5. Job Title: ……. Grade: ……..……
6. Current Facility: …….. Staff ID: …...……...

PART III: CONTACT DETAILS:

7. Contact Number: ……. Alternative Contact Number.: ……...
8. E-mail Address: …….……....
9. Work Place Address: …… Region: ……..

PART IV: DECLARATION

I, ……, wish to enroll as a dues paying member of the Medical Laboratory Professional Workers' Union. I pledge myself to abide by decisions of the Union, provisions of its constitution, rules and regulations. I hereby authorize the CAGD to deduct 1% of my monthly basic salary to pay the Union dues on my behalf using the check-off system. I solemnly declare that all information submitted on this form are true and valid. I authorize the Executives of the Union to use it for the purposes of my enrollment in the Union (MELPWU)..

Signature: …… **Date: …….**

FOR OFFICE USE ONLY

Regional Branch: …… Received By: ……..……

Date: ……...…… Vetted by: ……..……

Remarks: …… Registration No…….…… Certificate Issue Date: …….

Signature of General Secretary: ……..…..…… Date: ……