

ASSOCIATION OF DIAGNOSTIC IMAGING TECHNOLOGISTS

ADIT

SERVICE FEES DEDUCTION AUTHORIZATION

FOR: St. Francis:

I hereby authorize and direct my employer, Saint Francis Regional Medical Center, to deduct from my salary and to pay to the Association of Diagnostic Imaging Technologists (ADIT) the service fees designated below. If I am working 80 hours per pay period and receiving full-time benefits, the service fees deduction per pay period will be \$14.00. If I work part-time, scheduled 64 to 79 hours per pay period, the service fees deduction per pay period will be \$10.00. If I work part-time, scheduled less than 64 hours per pay period, the service fees deduction per pay period will be \$7.00. If I work casual (no regularly scheduled hours), the service fees deduction per pay period worked will be \$2.50.

I further authorize a one-time deduction of \$20.00, to be paid to ADIT, as an initiation fee. I will not have to pay an initiation fee, if I work casual.

I agree that if I resign my membership in ADIT, but continue to work for my employer, in an ADIT bargaining unit position, the amount set forth above will be deducted from my salary and paid to ADIT for the services provided by ADIT unless applicable federal or state laws permit me to pay a lesser amount.

This Authorization shall be altered in accordance with my employment status (full-time, part-time, or casual) when the Hospital gives ADIT written notice and the change will be effective the next pay period.

_____	Date: _____
(<u>Print</u> Employee's Name)	
_____	Date of Hire: _____
(Employee's Signature)	<u>Job Category:</u> (Please Check One)
_____	Licensed Practical Nurse _____
(Employee's Street Address)	Medical Laboratory Technician _____
_____	Respiratory Care Practitioner: _____
(Employee's City, State and Zip Code)	Polysomnographer _____
_____	Respiratory Intern _____
(Employee's Home Telephone # - Include Area Code)	Surgical Technologist _____
	Radiology:
	Diagnostic Imaging _____
	Special Imaging _____
	Multi-Specialty Imaging _____
	Nuclear Medicine _____
	Cardiac Sonographer _____
	Diagnostic Sonographer _____
	Radiology Intern _____
Total Hours per Pay Period: _____	Date of Status Change: _____

The Hospital should send copies of this Authorization to:

1) ADIT
13750 Crosstown Drive Northwest
Suite 108
Andover, MN 55304-5855
Office: 763-213-8252
Fax: 763-753-7463

2) Allina Service Center

*Revised 01-08