California Correctional Supervisors Organization, Inc.

MEMBERSHIP APPLICATION

Call: 1-800-449-2940

Mail: CCSO 1481 Ullrey Ave. Escalon, CA 95320 / Fax: 209-838-6759 / Scan and Email: CCSO@ccsonet.org

$67 MONTHLY DUES

MEMBERS RECEIVE:

- DEATH BENEFIT
- LEGAL REPRESENTATION
- LABOR REPRESENTATION
- POLITICAL REPRESENTATION
- EXECUTIVE LEVEL MEETINGS
- REPRESENTATION: CDCR, DSH, CCHCS, & CalHR
- DISCOUNTS ON INSURANCES

I hereby tender my application for membership in the California Correctional Supervisors Organization (CCSO), and authorize the State Controller to deduct from my salary and wages, the amount specified now or in the future for membership dues, and any benefit program for which I have applied, which is sponsored by the above named Organization, for the purpose of negotiating with my employer on my behalf on all matters affecting my employment relations. As a condition of membership in CCSO, I agree to abide by the Constitution and Bylaws of CCSO, and faithfully carry out my obligations under the same. Dues are payable in monthly installments, due the first day of each month. NOTE: CCSO Bylaw XII, Sec. 9 states, in part: "…the Organization does not incur any duty to represent any employee who joins the Organization after circumstances occur that prompt either a punitive action against said employee or a grievance from said employee…"

This authorization will remain in effect until canceled by the Organization, or at my written request, subject to the provisions of any agreement in effect between the State of California and CCSO, that apply to my classification. I understand that termination of my membership will cancel all deductions made under this authorization.

→ A percentage of your membership dues will be used for political action. Check here if you oppose ☐

Name: (Print)____Date:____________________

M: F:

Home Address:____

City: ___________________________________ State: ____________Zip Code:__________

Home Telephone: ____________________________Cell:______________________________

Email: ____

Rank/Title:__________________________Employed at Institution:_______________________

Birth Date: _________________________Social Security #:_____________________________

SIGNATURE: ____

→ CCSO member has a $5,000 death benefit, effective, once beneficiary is designated below on this card. The beneficiary must be 18 years of age. A minor, must have a designated co-beneficiary listed. Family member must contact the CCSO office within 60 days after member's death occurs.

Beneficiary____________________________________Contact Telephone #____________________

Beneficiary Address _________________________ City/State:_________________Relationship__________

Contingent Beneficiary______________________________Contact Telephone #____________________

Contingent Beneficiary Address__________________ City/State_________________Relationship__________