

DUES DEDUCTION CANCELLATION FORM

I hereby cancel my COHE dues deduction authorization, effective with the _____ (month/year) payroll period. I agree to pay to COHE any outstanding balance of unpaid membership dues prior to August 31.

Name _____

Social Security Number _____

Home Address _____

City/State/Zip _____

Department _____

Institution _____

Date _____

Signature _____

Date received by payroll office _____

NOTE: Payroll office will forward a copy of the completed form to the president of the institutional COHE chapter within five (5) days following receipt.