HEALTH WORKERS UNION

Don't be ripped off! Don't sign the new Clinical Lab's contracts.

The Health Workers' Union recommends that you NOT SIGN the contract that has been given to you.

The contract:

1. Refers to the wrong underlying award or agreement.
2. Contains a geographic clause where you can be sent around almost anywhere to work whenever Cinical Labs wants to. There will be no more certainty about where you're working day to day.
3. Gives the employer the right to engage in "7 day rostering" where you can be rostered to work at any time of the day or night and any time on weekends.
4. Has been distributed to staff with serious errors in it. The HWU offered our expertise but the employer went ahead without any discussions with the Union.

DO NOT BE PRESSURED BY THE "SIGN BY" DATE. IT IS DESIGNED TO MAKE YOU SIGN WITHOUT GETTING LEGAL ADVICE FROM YOUR UNION.

If you do not sign, you will continue to enjoy your current entitlements until a new agreement is made. If you sign you may not.

We anticipated that the takeover would lead to lower wages and worse conditions unless workers join together as a Union. This is the first step of this programme of cost cutting.

The Health Workers' Union has been in contact with Union members and provided them with the latest information. (Only Union members receive this information).

Please feel free to print off as many copies of the membership form attached to supply all employees at your worksite and return via Fax to: 03 9341 3334.

"Caring for our Caregivers"

State Secretary: Diana Asmar
Address: Level 5/222 Kings Way (PO Box 1088) South Melbourne, Victoria 3205
Ph: (03) 9341 3300 Fax: (03) 9341 3334 Email: info@hwu.org.au Website: www.hwu.org.au

HWU Membership Application Form

I wish to become a member of the Health Workers Union

Surname _____ Given Name(s) _____

Date of Birth __/__/__ Occupation/Classification _____

Worksite _____

Employment status *(please tick ✓)* Full Time ◯ Part Time ◯ Casual ◯ Hours worked per week _____

Address _____ Town/Suburb _____ Postcode _____

Email _____

Home Phone _____ Mobile _____

Work Phone _____

NOTE: Your contact details will only be used for union correspondence and WILL NOT be disclosed to third parties

Please choose from one of the following three payment options:

Direct Debit Request/Payment Schedule

◯ Fortnightly ◯ Monthly

Surname _____ Given(s) _____

BSB Number ☐☐☐☐☐☐ Account Number ☐☐☐☐☐☐☐☐☐

Name of Account to be Debited _____

Name of Financial Institution _____

Credit Card Payment/Payment Schedule

◯ Fortnightly ◯ Monthly

Please charge my Mastercard ◯ Visacard ◯ American Express ◯ $ _____

Card Number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiry Date __/__

Invoice Payments/Payment Schedule

◯ Please send my invoices to my address, listed above.

◯ Please send my invoices to the following address, listed below.

Address _____ Town/Suburb _____ Postcode _____

N.B. All invoices are sent on a quarterly basis (four times per year). Your first invoice will be sent when we get your application, and will include a pro-rata payment total for the period up until your first full quarterly statement.

◯ **I <u>do not</u> wish to be informed about Health Workers Union exclusive member discounts and benefits.**

By signing and/or providing us with a valid instruction in respect to your Direct Debit Request, you have understood this debit or charge will be made through the Bulk Electronic Clearing System (BECS) from your account held at the financial institution you have nominated above and will be subject to the terms and conditions of the Direct Debit Request Service Agreement and I am agreeing to the terms and conditions outlined on the back of this form.

Signature _____ Date __/__/__