

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.