IBEW Local 543
Disability for over 30 Days
Request for Adjustment of Dues

Name _____
(Print) (First) (Last)

Street Address _____

City_____ State _____ Zip Code _____

First Date of Absence: _____

Last Date of Absence: _____

_____ _____
(Employee Signature) (Date)

_____ _____
(Manager Signature) (Date)

IBEW Local 543
16519 Victor St. Ste 304
Victorville, CA 92395
(760)245-8147office
(760)245-7355fax