

SDEA

SDEA annually offers scholarships for members and their dependents.

Scholarship

I wish to donate per month: _____

(SDEA Scholarship Fund suggested contribution is \$5.00 per month.)

Name: _____

Employee ID: _____

Site/Program: _____

Personal Email: _____

Address: _____

I hereby acknowledge the following: (a) I am an employee of SDUSD; (b) I am a member of SDEA; (c) I am voluntarily authorizing the payroll deduction. Contributions are strictly voluntary and are not tax deductible, nor are they a condition of membership in SDEA, CTA, or NEA or any affiliated organization. A member may contribute more or less than the amount suggested on this form, or may decide to not make any contribution, and this will not affect his/her status, rights or benefits in SDEA or any of its affiliates. This authorization shall remain in force until canceled by written notice from SDEA or by the member who signed this authorization. I hereby authorize my employer to deduct from my salary and forward to SDEA Scholarship.

Signature: _____ Date: _____

**CONTRIBUTE TO THE
SDEA SCHOLARSHIP TODAY!**

Send form to SDEA: membership@sdea.net or fax (619) 282-7659