AEL MEMBERSHIP APPLICATION

Please email to Jessica

KLSNYDER1@aacps.org

(Please PRINT legibly, especially e-mail addresses)

DATE: ___/___/___

Dr. Ms. Mrs. Mr. _____ _____ _____

(First Name) (M.I.) (Last Name)

Home Street Address _____

City: _____State: _____ZIP: _____

Last 4 digits of your S.S. number _____ _____ _____ _____

Your personal E-Mail address _____

AACPS: E-Mail _____

[Circle one): AP, Principal, Supervisor, Coordinator, Other: _____

Current Work Location: _____

Work Phone: 410 - _____ _____

AEL ($532.50 Effective 8/1/2021) $ 532.50 ÷ 26 = $ 20.50 ___

Applicant Signature: _____

Date: _____

AEL Approval: _____

Date: _____

========== Administrator Use Only==========

Payroll Deduction Database: _____/_____/_____

Sick Leave Bank Database: Y N _____/_____/_____