

PART A—EMPLOYER INFORMATION

Idexx Reference Laboratories LTD.
10-1595 Cliveden Avenue, Delta BC V3M 6M2

PART B—MEMBER INFORMATION (personal)

Name: (optional) _____

Age: ☐ 25 & under ☐ 26-35 ☐ 36-45 ☐ Over 46

No. of Dependents: _____

PART C—MEMBER INFORMATION (work)

Job Classification: _____ Current Rate of Pay: _____ /mo.

Monthly rates of pay for past 3 years: (1) _____ (2) _____ (3) _____

Length of Employment (month/years): _____

Status: ☐ Regular Full-time ☐ Regular Part-time ☒ Casual/Auxiliary/On-Call

Current Benefits (please check)	Cost Sharing (i.e. 50/50 or):	Current Benefits (please check)	Cost Sharing (i.e. 50/50 or):
<input type="checkbox"/> Medical		<input type="checkbox"/> Long Term Disability	
<input type="checkbox"/> Extended Health		<input type="checkbox"/> Life Insurance	
<input type="checkbox"/> Dental		<input type="checkbox"/> Pension	
<input type="checkbox"/> Sick Leave		<input type="checkbox"/> Other	

How do you qualify to receive health and welfare benefits i.e. minimum number of hours worked, or?

Are you required to use your own vehicle for employer's business? ☐ Yes ☐ No

If you receive a mileage allowance, how much is it? _____ / kilometre _____ other.

PART D—PRIORITIES

(please assign a number from 1-5 according to your priorities, 5 being the highest priority)

	1	2	3	4	5
Dental Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Group Life Insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Job Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long Term Disability Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mileage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overtime Provisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paid Holidays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severance Pay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shift Scheduling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vacation Leave	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work Assigned/Seniority	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	1	2	3	4	5
Extended Health Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hours of Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Layoff and Recall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternity Lv. of Absence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occup. Health & Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paid Medical Premiums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pension Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shift Premiums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short Term Illness Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART E—OTHER ISSUES

(please list in order of priority any other issues which are important to you.)

COMMENTS:

PART F—OTHER EMPLOYERS

Do you work for another employer as well? ☐ Yes ☐ No

If yes, please answer the following:

(a) What employer?

(b) Are the employees represented by a union? ☐ Yes ☐ No

(c) What type of work do you perform for this other employer?

Your bargaining committee looks forward to your input.

Bargaining Committee:

Staff Representative:

<Bargaining Committee Member>

<Name of Staff Rep>

<Bargaining Committee Member>

<Phone>
(Phone)

<Fax>
(Fax)

<Bargaining Committee Member>

<Address>
(Address)

PLEASE RETURN TO THE STAFF REPRESENTATIVE

BY <DATE>