Committee of Interns and Residents
SEIU Healthcare

ROSETTA STONE DISCOUNT APPLICATION FORM

PART I: APPLICANT INFORMATION (PLEASE PRINT)

NAME: _____ _____
(Last Name) (First Name)

HOME ADDRES: _____
(Street)

_____ _____ _____
(City) (State) (Zip Code)

PHONE: (_____) _____ - _____ *__EMAIL__: _____
Check One: ☐Home ☐Mobile ☐Other

Hospital Where Employed: _____ Dept: _____

Please check: ☐ I understand that the Rosetta Stone Discount Benefit is available to CIR Members ONLY.
I confirm that I **am** a current CIR member and therefore eligible for this discount.

PART II: LANGUAGE SELECTION (PLEASE SELECT ONE)

☐ Arabic	☐ French	☐ Latin	☐ Spanish (Spain)
☐ Chinese (Mandarin)	☐ German	☐ Polish	
☐ English (American)	☐ Hindi	☐ Portuguese (Brazil)	
☐ English (British)	☐ Italian	☐ Spanish (Latin Amer.)	

PART III: PAYMENT METHOD (PLEASE SELECT OPTION)

☐ $225 for 1 year ☐ $160 for a 6-month trial ☐ $130 for 3-month trial

OPTION 1: CHECK PAYMENT
I have enclosed a check along with this form payable to CIR/SEIU in the amount of: _____

OPTION 2: CREDIT CARD PAYMENT (Please provide the following information.)

Card Type: _____ Expiration Date: _____

Card Number: _____

Billing Address: _____

*Signature Authorizing Use of Card: _____

Mail this form and accompanying payment to:
Committee of Interns & Residents/SEIU
520 Eighth Avenue, Suite 1200, New York, NY 10018
Attn: Peter Chang, Controller