

Oklahoma Academy of Ophthalmology
MEMBERSHIP APPLICATION



401 West 15th Street, Suite 825
Austin, TX 78701
Phone: (512) 370-1504 -- Fax: (512) 370-1637
Michael S. Duncan, Executive Director

PERSONAL DATA

First Name: _____ Middle Name: _____ Last Name: _____

Degree(s) (Circle all that apply): MD DO JD PhD

Date of birth: _____ Gender: Male Female

Marital Status: Single Married

If Married, Spouse's Full Name: _____

County of Residence: _____

Home Address: _____

Home phone: () _____ Home Fax: () _____ E-mail: _____

Where would you prefer receiving mail (check one): Home Primary office Secondary office

State Representative(s) and/or Senator(s) with whom you are acquainted: _____

PRACTICE / EDUCATION DATA

Number of years in practice: _____

Type of practice: Solo Group Clinic Academic Other: _____

Primary office address: _____

Primary office phone: () _____ Fax: () _____

Additional office location(s):

Address: _____

Phone: () _____ Fax: () _____

Address: _____

Phone: () _____ Fax: () _____

(over, please)

Medical School: _____ Graduation Date: _____

Residency: _____ Completion Date: _____

Fellowships: _____ Completion Date: _____

Institution: _____ Length (mo./yrs.): _____

ABO certified? Yes No If not, are you eligible? Yes No

Other certification? Yes No By Whom? _____

Year certified: _____ *Please attach a copy of the certification.*

State Medical License(s): State and Number: _____ Exp. Date: _____

State and Number: _____ Exp. Date: _____

PROFESSIONAL/HONORARY AFFILIATIONS

Military service (list dates and branch): _____

Hospital & university affiliations: _____

Other medical society memberships: _____

Positions held (after medical school, not including training): _____

REFERRING MEMBER

If you were referred to OAO by a colleague, please tell us: _____

MEMBERSHIP CATEGORY (Check one)

___ Active \$700 ___ Second year practicing in OK \$525

___ 1st year practicing in OK \$350 ___ Resident/Fellow (training) \$0

___ Military \$350

I hereby submit my application for membership in the Oklahoma Academy of Ophthalmology. This completed Membership Application includes my professional qualifications.

Signature: _____ Date: _____