



Oklahoma Academy of Ophthalmology

Application for Membership

Category (check one)

- Practicing Ophthalmologist \$700
- 1st year practicing in OK \$350
- 2nd year practicing in OK \$575
- Resident/Fellow \$0

General Information

| | | |
|--|--|--|
| Full Name | | Degree(s) |
| Primary Office Address (preferred address for mailing? <input type="checkbox"/>) | | |
| Home Address - not shared with anyone (preferred address for mailing? <input type="checkbox"/>) | | |
| Email Address: May other OAO members view this email address?: <input type="checkbox"/> yes <input type="checkbox"/> no | | |
| Preferred Phone Number | Preferred Fax Number | Include in "Find an EYE MD" public search? |
| Specialty within Ophthalmology | Location (cities) of any satellite offices | Date of Birth |

Education & Credentials

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|--|
| Medical Education (School & Completion Date) |
| Residencies/Fellowships (Programs & Completion Dates) |
| By signing below, you certify that: 1. The above information is true. 2. You hold a current, unrestricted license to practice medicine and surgery or osteopathic medicine and surgery in Oklahoma. 3. And you are engaged in the practice of ophthalmology in the State of Oklahoma. Or for Resident/Fellow Members, you are engaged full time in an accredited ophthalmology residency training program or fellowship in the State of Oklahoma. |

I hereby apply for membership in the OAO, and, if elected, agree to abide by its Constitution & Bylaws.

| | |
|---|---------------------|
| Signature | Date of Application |
| Please mail to: Oklahoma Academy of Ophthalmology, P.O. Box 684, Jefferson City, MO 65102 Phone: (573) 635-2173 Fax: (573) 635-2858 www.OklahomaEyes.org Please include payment per the dues schedule above. | |

Credit Card Payment

Card Number: _____
 CVV2 Number _____ (4-digit # on front of AmEx or 3-digit # on back of other cards)
 Name on Card: _____ Exp Date: _____
 Billing Address: _____