Ohio Ophthalmological Society

"Eye MDs and Surgeons Dedicated to Preserving Vision"

APPLICATION FOR MEMBERSHIP

As a practicing physician residing and/or practicing within the State of Ohio, and whose primary medical practice is ophthalmology or a combined practice of ophthalmology and otolaryngology, I hereby make application for Active Membership in the Ohio Ophthalmological Society and submit the following information in support of my request for this affiliation.

Please fill out entire application, both sides, completely. (Print or Type):

Full Name____*(**Circle one**)* MD or DO
First Middle Last

Practice Name____

Practice Associates____

Office Address_________________________**City**___________________**State**_______**Zip**________

Office Manager __________ ___________**Phone**______ ____ ______**Fax**___ _____________

E-Mail____________________ _________________ **Website**_________ ______________________

County (practice is in)_____ ___________ _____ **County** (home is in)___ _ _________ _________

Home Address ____

Home phone___________________ **Preferred Mailing Address** *(Circle one)* Office or Home

Date of Birth________________________ **Alternate languages spoken** _____________________
Gender (*Circle one)* M F

Education

Medical School ____ Year_________________

Internship ____ Years_________________

Residency ____ Years _________________

(**OVER**)

Current Professional Activity: (please check all that apply)

___ private practice solo ___ HMO employed ___ university employed
___ private practice group ___ hospital staff ___ retired
___ private practice multi-specialty ___ military ___ other ____________________

___ Resident (no dues required)

Practice Focus or Subspecialty:
(please check what is 50% or more of your practice or indicate board certification)

___ administration	___ general	___ plastic/reconstructive
___ anterior segment	___ glaucoma	___ refractive
___ cataract	___ IOL	___ research
___ CK Botox	___lasik	___retina vitreous
___ comprehensive	___macular degeneration	___strabismus
___ contact lenses	___ neuro-ophthalmology	___ uveitis
___ cornea	___oncology	___ pathology
___ diabetic eye care	___ orbital disease/surgery	___ pediatrics

License Expiration Date: __________

Payment Options

Enclosed is my check #_____________ Amount $__________ OR

Please charge my Visa/Mastercard/Discover #____

Expiration Date: _________ Security code (back of card) _ _ _ Amount $___________

Signature: ____**Date**: _____________

So that we may have further information about your education/academic appointments, etc. please submit a current C/V with your application.

Office use only
OSMB _______________
EPLS________________
OIG_________________