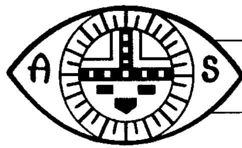

ARIZONA OPHTHALMOLOGICAL SOCIETY

ASSOCIATE MEMBERSHIP APPLICATION

NAME: ____
(Last) (First) (Middle)

MAIN PRACTICE ADDRESS: ______________________________________

OTHER PRACTICE LOCATIONS (NAME OF CITY[IES] ONLY): ______________________

____

HOME ADDRESS: ______________________________________

LEGISLATIVE DISTRICT: _______

E-MAIL: __________________ WEBSITE__________________

TELEPHONE: (OFFICE) ____________ (HOME) ____________

FAX: (OFFICE) ____________ (HOME) ____________

PREFER MAIL SENT TO: HOME______ OFFICE_____

MEDICAL LICENSE #: __________ STATE:______ DATE: __________

Primary SPECIALTY: ____________ BOARD CERTIF.? Y or N DATE: __________

Other Interests or Specialties (such as glaucoma, Lasik, etc.)

INTEREST OR SPECIALTY: ____________

INTEREST OR SPECIALTY: ____________

INTEREST OR SPECIALTY: ____________

MEDICAL SCHOOL: ______________________________

DEGREE: _________ YEAR OF GRADUATION: __________

INTERNSHIP: ____________________ DATES: _______ to _______

RESIDENCY: ____________________ DATES: _______ to _______

____________________ DATES: _______ to _______

FELLOWSHIP(S): ____________________ DATES: _______ to _______

____________________ DATES: _______ to _______

MEMBERSHIPS HELD IN OTHER MEDICAL ASSOCIATIONS:

☐ AMA ☐ ArMA

OTHER ______________________________________

____

Continued on reverse side>

CURRENT PRACTICE (Practice name, hospital, clinic, etc. and dates):

____

PLEASE LIST ANY CURRENT BUSINESS PARTNERS AND/OR ASSOCIATES:

1. ___________________________________
Typed Name

2. ___________________________________
Typed Name

3. ___________________________________
Typed Name

4. ___________________________________
Typed Name

NAME AND COMPLETE ADDRESS OF TWO REFERENCES SUPPORTING YOUR APPLICATION.
(Must be an MD or DO and may not be current business partners or associates)

1. ___________________________________
Typed Name

____
Email (preferred) or Mailing Address

2. ____
Typed Name

____
Email (preferred) or Mailing Address

APPLICANT'S SIGNATURE: _______________________________ DATE: ____________

PLEASE COMPLETE AND RETURN WITH CV TO:

ARIZONA OPHTHALMOLOGICAL SOCIETY
810 West Bethany Home Road, Phoenix, AZ 85013
(602) 347-6901 (602) 242-2515 fax

FOR OFFICE USE ONLY

Date Approved by AOS: _______________________