ARIZONA Ophthalmological Society
Eye Physicians and Surgeons

MEMBERSHIP APPLICATION

NAME: _____
(Last) (First) (Middle)

MAIN PRACTICE ADDRESS: _____

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

_____

HOME ADDRESS: _____

E-MAIL: _____ WEBSITE _____

TELEPHONE: (OFFICE) _____ (HOME) _____

FAX: (OFFICE) _____ (HOME) _____

PREFER MAIL SENT TO: HOME_____ OFFICE_____

MEDICAL LICENSE #: _____ STATE: _____ DATE: _____

Primary BOARD
SPECIALTY: _____ 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 _____

AZ HOSPITAL PRIVILEGES: _____

_____

MEMBERSHIPS HELD IN OTHER MEDICAL ASSOCIATIONS:

☐ American Academy of Ophthalmology ☐ American Medical Association ☐ Arizona Medical Association

OTHER _____

_____

Continued on reverse side>

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

_____

PLEASE LIST ANY CURRENT BUSINESS PARTNERS AND/OR ASSOCIATES:

1._____ 3._____
Typed Name Typed Name

2._____ 4._____
Typed Name Typed Name

NAME AND CONTACT INFORMATION OF AN ACTIVE SOCIETY MEMBER IN GOOD STANDING THAT WE CAN CONTACT TO PROVIDE A LETTER OF RECOMMENDATION FOR YOUR APPLICATION.

1._____
Typed Name

_____
Email (preferred) or Mailing Address

By signature of this application: I agree to abide by the policies set forth in the Arizona Ophthalmological Society Policy Manual and conform to the Code of Ethics of the Arizona Ophthalmological Society. A signed copy of the Code of Ethics must be included with the application, along with a current CV.

APPLICANT'S SIGNATURE: _____

DATE: _____

PLEASE COMPLETE AND RETURN WITH CV TO:
ARIZONA OPHTHALMOLOGICAL SOCIETY
2401 W Peoria Ave Ste 130, Phoenix, AZ 85029
602-347-6901 602-242-2515 fax
ldibiase@azmed.org
www.azeyemds.org

Date Approved by AOS: _____