Membership Application

Name ______________________	Referred By ______________________
Date of Birth ______________________	Sex: ☐ Male ☐ Female

Home Address ______________ City ______________ State ______ Zip ______

Telephone ______________________	Email ______________________

Business Address ______________ City ______________ State ______ Zip ______

Business Telephone ______________________	Fax ______________________

Preferred Mailing Address: ☐ Home ☐ Business

You are joining the Local Society in which you: ☐ Live ☐ Work ☐ Other

If you checked, "other", please specify ______________________	New York State License Number/Original Date of Licensure ______________________

Are you licensed to practice in any other states? ☐ Yes ☐ No Please list: ______________________

Number of years in practice ______________________	Number of hours worked per week ______________________

Are you a member of any other optometric societies? ☐ Yes ☐ No

If so, please list: ______________________

Are you transferring from another state? ☐ Yes ☐ No

Optometry School Attended ______________________	Graduation Year ______________________

Did you complete a residency? ☐ Yes ☐ No Year: ______________

Are you a faculty member of SUNYCO? ☐ Yes ☐ No

If yes, number of hours per week at SUNYCO: ______________________

Is your spouse a current member? ☐ Yes ☐ No Name: ______________

Has your certificate of registration ever been revoked, annulled or suspended? If Yes, please attach a letter of explanation ☐ Yes ☐ No

Referral Listing:

☐ Academy FAAO	☐ Contact Lenses	☐ General	☐ Refractive Surgery
☐ House Calls	☐ Low Vision	☐ Sports Vision	☐ Vision Therapy
☐ Medicaid	☐ Medicare	☐ DPA Certified	☐ TPA Certified
☐ TPA 2 Certified			

To the Secretary of
The New York State Optometric Association, Inc.

I, ____ am applying for membership in the_______________________________________ Optometric Society, the New York State Optometric Association, Inc., and the American Optometric Association. I agree to abide by the Constitution and By-Laws, and to adhere faithfully to the Code of Ethics of the New York State Optometric Association, Inc. and the American Optometric Association.

Signed ____

Name in Full

Date of Application: ____________________________

Upon approval of membership application, a dues statement will be sent to you at your preferred mailing address. Monthly or quarterly dues payments are available upon request.