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### APPLICATION FOR NYSOS MEMBERSHIP

#### PERSONAL INFORMATION

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Title (check all that apply):  MD  DO  PhD  JD  Other: \_\_\_\_\_

Home Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Phone: ( ) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Business Email: \_\_\_\_\_ Alternate Email: \_\_\_\_\_

#### PRACTICE INFORMATION

Primary Office Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Satellite Office Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Medical License No: \_\_\_\_\_ State Issued: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Number of Years in Practice: \_\_\_\_\_

Type of Practice:  Solo Private Practice  Hospital-Based  HMO  
 Group Private Practice  University-Based

Subspecialty/Practice Focus: (Fellowship trained or ≥50% of practice)  
 Cornea/External Disease  Oncology  
 General  Pediatric  
 Glaucoma  Refractive Surgery  
 Medical Retina  Retina/Vitreous  
 Neuro  Other: \_\_\_\_\_  
 Oculoplastics

Hospital Appointments: \_\_\_\_\_  
\_\_\_\_\_

## EDUCATION

Premedical Education: \_\_\_\_\_ Degree: \_\_\_\_\_ Completion Date: \_\_\_\_\_  
(College or University)

Medical School: \_\_\_\_\_ Completion Date: \_\_\_\_\_

Residency: \_\_\_\_\_ Completion Date: \_\_\_\_\_

Fellowship(s): \_\_\_\_\_ Completion Date: \_\_\_\_\_

ABO Certification: Yes No Year: \_\_\_\_\_ (If no, are you eligible? Yes No)

Other certification: Yes No (If yes, by whom: \_\_\_\_\_)

## PROFESSIONAL/HONORARY AFFILIATIONS

Medical Society Memberships:

- American Academy of Ophthalmology
- American Medical Association
- American Society of Cataract & Refractive Surgery
- Medical Society of the State of New York
- Regional Ophthalmological Society
- Other: \_\_\_\_\_

## AREAS OF INTEREST

Please check all that apply:

- Third Party Payer Issues
- State Legislation
- Federal Legislation
- Membership
- Public Education
- Clinical Education
- Resident Advocacy Education
- Ophthalmic Staff Education
- Other: \_\_\_\_\_

*I hereby submit my application for membership in the New York State Ophthalmological Society and in signing this application agree to abide by the organization's By-laws.*

Signature: \_\_\_\_\_

Date: \_\_\_\_\_