



OKLAHOMA ASSOCIATION of OPTOMETRIC PHYSICIANS

APPLICATION FOR MEMBERSHIP

Date of Application: _____

I hereby apply for active membership in the Oklahoma Association of Optometric Physicians. If granted membership into the Association, I will abide by its bylaws, and the OAOP Code of Ethics, and agree to pay all dues and assessments promptly. I agree to keep in confidence professional and confidential information as may be supplied by the Association.

Active membership is open to anyone licensed by the Oklahoma State Board of Examiners in Optometry and actively practicing optometry in Oklahoma or serving in a branch of United States Armed Forces upon endorsement, approval, and election by the OAOP board and its membership.

Print Name: _____
(First) (Middle) (Last) (Designation)

Signature of Applicant: _____

PRIMARY OFFICE

Street Address: _____ Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____ Email: _____

If you have more than one office please list company name and address below:

Mail Preference: Primary Office Satellite Office Home

RESIDENCE

Home Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____ Email: _____

MEMBERSHIP INFORMATION

Previous OAOP Affiliation Yes No If yes, state when and reason for terminating membership?

Previous AOA Affiliation Yes No If yes, when? _____

PROFESSIONAL DATA

School of Optometry: _____ Year of Graduation: _____

OK License Number: _____ Date Licensed: _____

Do you hold a license of optometry in another state(s)? Yes No If yes, please indicate the following:

State(s): _____ License Number(s)/Year(s): _____

Residency: Yes No If yes, please indicate: When: _____ Where: _____

Assignment for: Medicare: Yes No Medicaid: Yes No



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PRACTICE SETTING

Check here if applicable: Employed Part-time (up to 20 hours total per week) Current Military

Indicate mode(s) of practice by **checking** all that apply and **circle your primary setting**, if more than one.

Self-employed:

- Solo
- Partnership/Group

List partner(s):

Employed by:

- Optometrist _____
- Ophthalmologist _____
- Hospital/Clinic/Other Multidisciplinary _____
- Armed Forces/VA/USPHS _____
- School/University _____
- Other (specify): _____

Not currently active in optometry:

- Retired
- Unemployed
- Other (specify): _____

Hospital Privileges: Yes No If yes, list the name and location of the hospital: _____

Specialties: Contact Lens Vision Therapy Low Vision Other _____

POLITICAL INFORMATION

Party Affiliation: Republican Democrat Independent Reform Unknown

List any political contacts: _____

Are you comfortable responding to the media? Yes No

PERSONAL INFORMATION

Gender: Male Female If applicant is *female*, please list maiden name: _____

Date of Birth: _____

Marital Status: Married Single Name of Spouse (if applicable): _____

Is your spouse an Optometrist: Yes No

Children's Names: _____

Religious/Spiritual Affiliation: _____

Please return application & payment to: OK Association of Optometric Physicians 4850 N. Lincoln Blvd, Ste A
 Oklahoma City, OK 73105

OAOP OFFICE USE ONLY

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|---------------------------|--|-------------------------|--|
| Date Received: | | AOA Dues: | |
| Membership Status: | | OAOP Dues: | |
| Amount Enclosed: | | Check No: | |
| Visa/MC No | | Expiration Date: | |