

**Minnesota Academy of Ophthalmology
MEMBERSHIP APPLICATION**

3880 Laverne Avenue North
Suite 114
Lake Elmo MN 55042
Phone 651/645-2452 FAX: 651/773-5914
Contact: Kris Wallerich, Executive Director
(Please type or print)

PERSONAL DATA

First name: _____ Middle initial: _____ Last name: _____

Title (check all that apply): MD DO Ph.D. JD OD other: _____

Date of birth: _____ Email address: _____

Marital status: M S If married, spouse's name: _____

County of residence: _____

Home address: _____

Home phone: _____ Home FAX: _____

Where would you prefer receiving mail (check one): home primary office satellite office

State Representative(s) and/or Senator(s) with whom you are acquainted: _____

PRACTICE DATA

Number of years in practice: _____

Type of practice: solo group clinic academic other: _____

If group practice, how many ophthalmologists are in the group? _____

Primary office address: _____

Primary office phone: _____ FAX: _____

Days in primary office (check all that apply): M T W Th F S

Satellite office address: _____

Satellite office phone: _____ FAX: _____

Days in satellite office (check all that apply): M T W Th F S

Subspecialty: _____

Please continue on reverse side.

Positions held (after medical school, not including training): _____

EDUCATION

Medical school: _____ Grad date: _____

Residency: _____ Completion date: _____

Fellowships: _____ Completion date: _____

ABO certified? Yes No (If no, are you eligible? Yes No)

Other certification? Yes No By whom: _____

Year certified: _____ Please attach a copy of the certification.

Medical License Number: _____ State issued: _____ Expiration date: _____

Please include a copy of your C.V.

PROFESSIONAL/HONORARY AFFILIATIONS

Military service (date and branch): _____

Hospital & university affiliations: _____

Other medical society memberships: _____

MEMBERSHIP CATEGORIES (check one) Dues will be assessed after election to membership.

- Active \$850
 - First year in practice \$200
 - Second year in practice \$400
- Part-time -- (works less than 30 hours per week) Board Review
- Resident/fellow -- (training) \$25
- Out-of-State \$100

Recommended by (must be completed by ophthalmologists licensed to practice in Minnesota):

1) _____
name address

2) _____
name address

I understand that by providing my mailing address, email address, telephone and fax numbers I consent to receive communications sent by or on behalf of MAO via regular mail, email, telephone or fax. I hereby submit my application for membership in the Minnesota Academy of Ophthalmology. I have included a copy of my CV with this completed membership application.

Signature: _____ Date: _____