

Have you been a member of the AAO before? ☐ Yes ☐ No

If Yes, AAO Member ID (if known) \_\_\_\_\_

## PERSONAL INFORMATION

Family/Surname

First Name

Middle Initial

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

Gender: ☐ Male ☐ Female

## PRIMARY MAILING ADDRESS

Primary Address for All AAO Mailing: ☐ Home ☐ Office

Street Address

Street Address

City

State/Province/District

Postal Code

Country

Other Location (Optional): ☐ Home ☐ Office

Street Address

Street Address

City

State/Province/District

Postal Code

Country

## CONTACT INFORMATION

Office Number

Fax Number

Home Number

Cell/Mobile

**Primary Email** *(Will be used to log in and retrieve passwords. Cannot match any other user's primary email.) (Required)*

**Communication Email** *(Academy communications will go to Primary Email unless this field is completed.) (Optional)*

## EDUCATION

### Medical Training *(Required)*

University/School Name

City, State, and Country

Degree \_\_\_\_\_ Completion: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

### Ophthalmology Training *(Required)*

University/School Name

City, State, and Country

Begin Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Completion Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY MM DD YYYY

### Fellowship/Additional Training *(If Applicable)*

University/School Name

City, State, and Country

Type of Study (ie. cornea, retina, etc.)

Begin Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Completion Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY MM DD YYYY

If you are currently in a **full-time ophthalmology training program**, you must provide the name and signature from your program director or submit a verification letter. Beginning and end dates of training must be included in the letter.

Print Program Director Name

Signature of Program Director

If you are a **practicing ophthalmologist**, you must provide the names of two ophthalmologists to support your application. The ophthalmologist does not need to be an AAO member.

Reference Name

Reference Name

### Professional Information

Are you certified by the following? ☐ Yes ☐ No

American Board of Ophthalmology

\_\_\_\_ / \_\_\_\_  
MM YYYY

\*American Osteopathic Board of Ophthalmology

\_\_\_\_ / \_\_\_\_  
MM YYYY

\*Royal College of Surgeons

\_\_\_\_ / \_\_\_\_  
MM YYYY

\*Please note that certificate must accompany application.

### Practice Restrictions

Have you been convicted of a felony within the last 7 years? ☐ Yes ☐ No

Have you ever had hospital privileges denied, revoked, conditioned, suspended, limited, qualified, or subject to the terms of probation or restricted?

☐ Yes ☐ No

Have you voluntarily surrendered your hospital privileges? ☐ Yes ☐ No

If yes to any questions above, please explain fully and attach with your application.

By submitting this application for AAO membership, **I agree** 1) all information submitted on or in support of this application is true, accurate and complete; 2) to comply with the AAO's Code of Ethics and 3) to abide by its Bylaws. **I understand** 1) my application is subject to verification by the AAO and release the AAO from any claims, damages or liabilities related to or arising from the verification process; 2) my membership must be recommended by the Board of Trustees and approved by election of the AAO voting membership; and 3) the AAO may revoke my membership.

Signature

Date

\* **Application Fee** (Application fee must be enclosed and is non-refundable.)

- |  |             |
|--|-------------|
| <input type="checkbox"/> Active Fellow or Osteopathic Fellow       | \$925 (USD) |
| <input type="checkbox"/> Active Member                             | \$925 (USD) |
| <input type="checkbox"/> Second Year in Practice (U.S. only)       | \$650 (USD) |
| <input type="checkbox"/> First Year in Practice (U.S. only)        | \$425 (USD) |
| <input type="checkbox"/> International Member                      | \$495 (USD) |
| <input type="checkbox"/> International Member in Training          | \$160 (USD) |
| <input type="checkbox"/> Member in Training (U.S. and Canada only) | Waived      |

\* Fee covers membership from application date through December 31.

An **Active Fellow/Osteopathic Fellow** is a practicing ophthalmologist certified by the American Board of Ophthalmology, American Osteopathic Board of Ophthalmology or the Royal College of Physicians and Surgeons. An **Active Member** is an ophthalmologist who is not board certified and practicing within or outside of the U.S. The **first and second year in practice** are for ophthalmologists in their first and second year of practicing within the U.S. These categories are strictly based on the last year of training. An **International Member** is an ophthalmologist practicing outside the U.S. An **International Member in Training** is a physician doing an ophthalmology residency or fellowship training outside the U.S. A **Member in Training** is a physician doing an ophthalmology residency or fellowship training within the U.S. and Canada.

**Payment Information:** ☐ American Express ☐ Discover ☐ JCB ☐ MasterCard ☐ Visa ☐ Bank Draft ☐ Wire Transfer

Card Number

Expiration Date

Name on Card

Cardholder's Address

City/State/Postal Code

Country

**Make check/bank draft payable on a U.S. bank in U.S. dollars to American Academy of Ophthalmology.**

### For International Transfers:

Wells Fargo Bank, NA  
San Francisco, CA  
Swift#: WFBUS6WFFX  
Account#: 4121478242  
Account Name: American Academy of Ophthalmology  
(Please include full name on transfer)

### Return your completed application with payment to:

American Academy of Ophthalmology  
Dept #34048  
PO Box 39000  
San Francisco, CA 94139  
USA

### Fax your completed application to:

+1.415.561.8575 (the AAO does not recommend that you email applications with credit card information)

### Direct inquiries to:

American Academy of Ophthalmology  
Member Services  
655 Beach Street  
San Francisco, CA 94109-1336  
USA  
Tel: +1.415.561.8581  
Email: [member\\_services@aao.org](mailto:member_services@aao.org)

### For office staff only

Membership Year: \_\_\_\_\_