



## Membership Application (Please print clearly)

### APPLICATION DEADLINE AUGUST 15

Date of Application \_\_\_\_\_

Are you a previous member of AAO? ☐ 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 \_\_\_\_\_

### PHONE

Office Number \_\_\_\_\_

Fax Number \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell/Mobile \_\_\_\_\_

### EMAIL

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

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

### EDUCATION

#### MEDICAL TRAINING (Required)

University/School Name \_\_\_\_\_

City, State, and Country \_\_\_\_\_

Degree \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)

#### OPHTHALMOLOGY TRAINING (Required)

University/School Name \_\_\_\_\_

City, State, and Country \_\_\_\_\_

Begin Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Completion Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)

#### FELLOWSHIP/ADDITIONAL TRAINING (If Applicable)

University/School Name \_\_\_\_\_

City, State, and Country \_\_\_\_\_

Type of Study (i.e. cornea, retina, etc.) \_\_\_\_\_

Begin Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Completion Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (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 **must** be included in this letter.

Print Program Director Name \_\_\_\_\_

Signature of Program Director \_\_\_\_\_

If you are a **practicing ophthalmologist**, you must provide 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 crime 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 affirm that my medical license is valid and unencumbered in each state in which I am licensed. I further affirm that all information submitted on or in support of this application is true, accurate and complete. I agree 1) to comply with the AAO's Code of Ethics and 2) to abide by its Bylaws. I understand 1) my application is subject to verification by the AAO, and I 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

### Direct inquiries to:

American Academy of Ophthalmology  
Member Services  
655 Beach St  
San Francisco, CA 94109-1336  
USA  
Tel: +1.415.561.8581  
Email: member\_services@aao.org

### 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)

## APPLICATION FEE (Application fee must be enclosed and is non-refundable)

☐ **Active Fellow or Osteopathic Fellow** \$950 (USD)

☐ **Active Member** \$950 (USD)

☐ **Second Year in Practice** (U.S. only) \$650 (USD)

☐ **First Year in Practice** (U.S. only) \$425 (USD)

☐ **International Member** \$495 (USD)

☐ **International Member in Training** \$160 (USD)

☐ **Member in Training** (U.S. and Canada only) Waived

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** categories are for ophthalmologist in their first and second year of practicing within the U.S. 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)

For office staff only

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