

You can send this form to: American Academy of Ophthalmology P.O. Box 7424 San Francisco, CA 94120-7424 Attn: Member Services. You can also fax this form to 1.415.561.8575. If you have any questions regarding your membership, please contact any Member Services Representative by phone 866.561.8558, fax 415.561.8575 or **email member\_services@aao.org**

**A. New Academy Membership Category**

- I **completed** training in \_\_\_\_\_ (year) and I am **not Board Certified**. Please elevate my category to **Active Member for \_\_\_\_\_**.
- I **completed** training in \_\_\_\_\_ and I am **board certified**. Please elevate my category to **Active Fellow** or **Active Osteopathic Fellow for \_\_\_\_\_**. *The only acceptable certifying boards for Active Fellow are the American Board of Ophthalmology, American Osteopathic Board of Ophthalmology and the Royal College of Physicians and Surgeons of Canada. If you are certified by the Royal College of Physicians and Surgeons of Canada, you must attach a copy of your certificate.*  
 Name of Board..... Year of Certification.....
- I **completed** my training in \_\_\_\_\_ and practice **outside** of the United States. Please elevate my category to **International Member**.
- I will begin or plan to continue my training in \_\_\_\_\_. Please change my category to Member in Training/International Member in Training for \_\_\_\_\_ (if this category is selected, please complete Section B)

**B. Statement of Verification for Continuation of Training**

*To be eligible to remain in the Member in Training membership category, your new Program Director/Chair must sign this verification form, or a copy of your letter of acceptance must be attached. The **From** and **to** dates must be completed.*

I will begin or plan to **continue** in an ophthalmology training program in \_\_\_\_\_.

This program is a:  Residency                       Fellowship                       Other Ophthalmology Training Program

Name of Other Ophthalmology Training Program.....

Name of Medical Institution.....

City/State or City/Country.....

*Please Print*

Signature of Program Director/Chair.....

*(or copy of letter of acceptance-must include beginning and completion dates)*

Type of Study.....

Beginning/Projected Completion Dates – From ...../..... To ...../.....

**Change of Address**

*If you would like to change the address for all of your Academy mailings, make changes in the space provided below. Please be sure to provide your full name, Academy ID number, phone/fax numbers, and e-mail address.*

Full Name: ..... Academy Number: .....

Change of Address: .....

.....

Phone: ..... E-mail .....

Fax: .....