



# American Academy of Ophthalmic Executives® (AAOE®) Membership Application

Physician applicant must be a member of the American Academy of Ophthalmology.

Academy Member Number (Required)

Last Name	First Name	Middle Initial
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Credential(s): (Check all that apply)  MD  DO  PhD  MBA  MPH

Practice Name

Practice Address

City	State	Zip	Country
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Telephone	Fax
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Email - Used to log into your account. Cannot match any other user's email. (Required)

I consent to the Academy keeping me informed through member-exclusive newsletters and timely communications about the annual meeting, education, products and services that it provides to the ophthalmology community at large.

**PAYMENT \$299** (Membership is from January 1 to December 31, 2023)

VISA  MasterCard  AMEX  Discover  Check or money order, payable to AAO

Card Number	Exp. Date	Authorized Signature
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Name on Card

Cardholder's Billing Address

City	State	Zip	Country
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I understand and agree that I must be a member of the American Academy of Ophthalmology. I further agree that if I violate the foregoing statement, my membership in AAOE will be terminated immediately and no membership or other fees will be refunded.

Signature	Date
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RETURN THIS FORM TO: American Academy of Ophthalmology  
PO Box 884048  
Los Angeles, CA 90088-4048

QUESTIONS? Contact Member Services  
T: +1 415.561.8581  
E: member\_services@aao.org

F: +1 415.561.8575