APPLICATION FOR MEMBERSHIP

Missouri Optometric Association

PERSONAL INFORMATION:

First Name | Middle Initial | Maiden Name (if applicable) | Last Name | SSN

Address | City | State | Zip Code

Date of Birth | M/F | County | Home Phone | E-mail Address | Spouse's Name

BUSINESS INFORMATION:

Name of Practice

Address | City | State | Zip Code

Phone | Fax | E-Mail Address

BILLING/MAILING INFORMATION:

Method of Dues Payment:
❑ Annual ❑ Quarterly ❑ Monthly

Preferred Mailing Address:
❑ Home Address ❑ Business Address

TYPE OF MEMBERSHIP:

❒ New ❒ Reinstatement ❒ Faculty Associate
❒ Federal Services ❒ Special Class ❒ Non-Resident
❒ Student ❒ Partial Practice – hours worked per week:_____

❒ May we contact you by e-mail: ❒ Yes ❒ No

For the American Optometric Association's purposes ONLY, your preferred method of contact: ❒ E-mail ❒ Mail

PROFESSIONAL INFORMATION:

School of Optometry Attended | Graduation Date (Mo/Day/Yr)

Address | City | State | Zip Code

Have you completed a residency? ❑ Yes ❑ No

If yes, identify where and time completed (start date and completion date)

License Number: _____ Date of Licensure: _____

License Expires: _____

DPA Certified? ❑ Yes ❑ No ❑ Pending

TPA Certified? ❑ Yes ❑ No ❑ Pending

Have you ever been licensed in another state? ❑ Yes ❑ No

If yes, what state(s)_____When Licensed_____ Active? ❑ Yes ❑ No

Are you currently a member of another state association? ❑ Yes ❑ No If yes, what state _____

_____ _____
Signature Date

< < < < < < < < > > > > > > > >

Return completed form to: Missouri Optometric Association • 100 E. High St., Ste. 301 • Jefferson City, MO 65101
Questions? Call 573/635-6151 • Email: moopt@socket.net • Fax: 573/635-7989