

MEMBERSHIP APPLICATION

P.O. Box 13429  
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Tallahassee, FL 32317  
Phone: (800) 399-2334  
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# Florida Optometric Association (www.floridaeyes.org)

**NAME:** \_\_\_\_\_  
Last First Middle Surname

**ADDRESSES:**  
**Office:** \_\_\_\_\_ **Home:** \_\_\_\_\_  
Street number or PO Box Street number or PO Box

\_\_\_\_\_  
City State Zip City State Zip

\_\_\_\_\_  
County County

**TELEPHONES:**  
 \_\_\_\_\_  
Office Home Fax Email Address (print clearly)

Please send **all** correspondence to my:  HOME  OFFICE  
 (The address you select above will be used for all membership listings, directories, etc., and to determine local society membership)

**BIRTHDATE:** \_\_\_\_\_ **MARITAL STATUS:**  Single  Married: \_\_\_\_\_  
MM/DD/YYYY Spouse's Name

**LICENSING INFORMATION:**  
 Optometry School: \_\_\_\_\_ Year Graduated: \_\_\_\_\_

FL. License #: \_\_\_\_\_ First FL. License: \_\_\_\_\_ Other State License: \_\_\_\_\_  
YEAR YEAR/STATE

Residency:  NO  YES: What year did/does it end? \_\_\_\_\_

<b>MEMBERSHIP CATEGORY (Check only one)</b>		<b>OPTOMETRIC SPECIALTIES (check two)</b>	
<input type="checkbox"/> Regular	<input type="checkbox"/> AOA/FOA Retired	<input type="checkbox"/> Contact Lenses	<input type="checkbox"/> Ortho-keratology
<input type="checkbox"/> Partial Practice	<input type="checkbox"/> FOA Retired	<input type="checkbox"/> Low Vision	<input type="checkbox"/> Vis. Therapy
<input type="checkbox"/> Special Class*	<input type="checkbox"/> Life Member	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Other
<input type="checkbox"/> Associate	<input type="checkbox"/> Student		

I, \_\_\_\_\_, an optometrist of good repute, having taken the Florida State Board of Optometry Examination for licensure, hereby make application in accordance with the Florida Association's rules of membership.

I understand the Executive Committee has authority and is charged with the responsibility for proper investigation of the facts set forth in this application, to give due consideration to my moral character and, if found properly qualified and endorsed by a majority of the Executive Committee, that I will be entitled to have my name enrolled by the Secretary-Treasurer as a member of the Florida Optometric Association. I hereby specifically consent to this procedure.

By submission of this application I agree to comply with the by-laws and to practice in accordance with the code of ethics of the Florida Optometric Association.