

MEMBERSHIP APPLICATION

WEST VIRGINIA ACADEMY OF OPHTHALMOLOGY

Suite 220, 2110 Kanawha Blvd., East
Charleston, WV 25311

TELEPHONE: 304-343-5842 FAX: 304-344-4139 E-MAIL: wvao@wvmtg.com

CONTACT: Nancy S. Tonkin, Executive Director

PERSONAL DATA:

First Name: _____ Middle Initial: _____ Last Name: _____

Title: (circle all that apply) MD DO PhD JD OD Other: _____

Date of birth: _____

Marital Status: M S If married, spouse's name: _____

County of residence: _____

Home address: _____

Home telephone: _____ Home fax: _____ Home E-mail: _____

Where would you prefer receiving mail (check one) home primary office satellite office

State Representative(s) and/or Senator(s) with whom you are acquainted: _____

PRACTICE DATA:

Number of years in practice: _____

Type of practice: _____

Primary office address: _____

Primary office phone: _____ Fax: _____ E-Mail: _____

Satellite office address: _____

Satellite office phone: _____ Fax: _____ E-Mail: _____

Subspecialty: _____

Positions held after medical school, not including training: _____

EDUCATION:

Medical School: _____ Graduation date: _____

Residency: _____ Completion date: _____

Fellowships: _____ Completion date: _____

(OVER)

ABO certified? Yes No If no, are you eligible? Yes No

Other certification? Yes No By Whom: _____

Year certified: _____ Please attach a copy of this certification.

Medical License Number: _____ State issued: _____ Expiration date: _____

Please list your scientific articles and other publications (attach additional sheets if necessary):

PROFESSIONAL/HONORARY AFFILIATIONS:

Military service (branch and dates): _____

Hospital & University affiliations: _____

Member of AAO? Yes No

Other medical society memberships: _____

MEMBERSHIP CATEGORIES (check one) Dues are based on number of years in practice, not number of years as a WVAO member and will be assessed after election to membership.

Active: In practice 3 or more years and work 30 or more hours per week: \$750.00

First year practitioner: \$350.00

Second year practitioner: \$550.00

Resident/fellow in training: waived

Two recommendations by WVAO member ophthalmologists licensed to practice in West Virginia are required:

1. _____
(Name) (Address)

2. _____
(Name) (Address)

I hereby submit my application for membership in the West Virginia Academy of Ophthalmology (WVAO). This completed membership application includes my professional qualifications.

Signature: _____ Date: _____