OHIO OPTOMETRIC ASSOCIATION

2018 ACTIVE MEMBERSHIP APPLICATION

FAX (614-781-6521), EMAIL (info@ooa.org), or MAIL completed application to the Ohio Optometric Association

Full Name _____ Suffix (Jr, Sr, etc) _____

Maiden (if applicable) _____ Designations (OD, PhD, etc) _____

Home Mailing Address _____

City _____ State _____ Zip _____

Business/Organization Name _____

Mailing Address _____

City _____ State _____ Zip _____

Contact Preference ☐ **Home** ☐ **Business**

Mobile Phone_____ Work Phone _____

Home Phone _____ Fax _____

Preferred Email _____

Date of Birth _____ Gender: ☐ Female ☐ Male ☐ Choose not to disclose

Primary Practice Setting: _____ **Secondary Practice: _____** **Other Practice Setting: _____**

Self Employed:	**Employed By**:
A. 1 doctor- not affiliated with regional/national company B. 2-4 doctors - not affiliated with regional/national company C. 5+ doctors - not affiliated with regional/national company D. Franchisee - 1 OD affiliated with regional/national company E. Franchisee - Multiple ODs affiliated with regional/national company F. Lessee – affiliated with regional/national company G. Other Self-Employed U. Independent Contractor	H. Optometrist(s) not affiliated with regional/national company I. Ophthalmologist(s) J. HMO K. Hospital/Clinic/Other Multidisciplinary L. Regional/National Company M. Armed Forces/VA/USPHS/ IHS N. Educational Institution O. Local/State/Federal Government P. Optical/Ophthalmic Manufacturer or Wholesaler Q. Other Employed V. Optometrist(s) affiliated with regional/national company W. Non-Optometry-Owned Independent Franchise/Optical

PO Box 6036, Worthington OH 43085 • 614-781-0708 • FAX 614-781-6521 • EMAIL info@ooa.org

Optometry School Attended _____ Graduation Date _____

OH License Number _____ Year Obtained _____

Other States Licenses (ST/#) _____ Original License Year (if different than OH) _____

Years of Residency (if applicable) _____ Location of Residency _____

The following section is voluntary.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Unknown ☐ Choose not to disclose

Name of spouse (if applicable) _____

Political Affiliation: ☐ Democrat ☐ Republican ☐ Independent ☐ Libertarian ☐ Green ☐ Unknown ☐ Choose not to disclose

Ethnicity/Race: ☐ Hispanic/Latino ☐ White ☐ Black/African American ☐ Asian ☐ Native American ☐ Alaska Native/Pacific Islander ☐ Other ☐ Choose not to disclose

Military Service:

Branch: ☐ Army ☐ Marine Corps ☐ Navy ☐ Air Force ☐ Coast Guard ☐ National Guard

Status: ☐ Active ☐ Inactive ☐ Deactivated ☐ Reserves ☐ Retired

I hereby apply for membership in the Ohio Optometric Association and the American Optometric Association. I understand fully, and will adhere to, the schedule of dues payment and Association Bylaws and Code of Ethics.

Signature _____ *Date* _____

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