OHIO OPTOMETRIC ASSOCIATION

2020 Dues
10/31/19

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) _____

Mailing Contact Preference ☐ Home ☐ Work

Home Mailing Address _____

City _____ State _____ Zip _____

Primary Practice/Organization Name _____

Mailing Address _____

City _____ State _____ Zip _____

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. Owner – OD Private Practice; not affiliated with regional/national company	H. 2-4 OD Private Practice; not affiliated with regional/national company
B. Owner – 2-4 OD Private Practice; not affiliated with regional/national company	I. 5+ OD Private Practice; not affiliated with regional/national company Private
C. Partner – 5+ OD Private Practice; not affiliated with regional/national company	J. Regional/National Company
D. OD Franchisee; affiliated with regional/national company	K. Multi-Discipline/Ophthalmology Practice
E. Multiple OD Franchisee; affiliated with regional/national company	L. University
F. Lessee; affiliated with regional/national company	M. Hospital/Clinic
G. Independent Contractor	N. VA Hospital/Clinic
	O. FQHC/School Based Health Center
	P. Optical/Ophthalmic Manufacturer or Wholesaler
	Q. Other Employed

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

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Optometry School _____ Graduation Date _____

Year(s) of Residency (if applicable) _____ Location _____

OH License Number _____ Year Obtained _____

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

The following section is voluntary.

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

Name of spouse (if applicable) _____

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

Ohio Optometric Association CODE OF ETHICS:

1. To practice the art and science of optometry faithfully and conscientiously, and to the fullest scope of the most current standards of care and competency of the honorable profession of optometry.
2. To uphold and promote by example and action the highest standards, ethics, and ideals of our chosen profession.
3. To provide professional care for those who seek our services with concern, compassion, and due regard for their human rights, dignity, and privacy, without discrimination or financial consideration.
4. To place the needs of the patient above all else in order to better care for their visual performance and comfort as well as their ocular and systemic health with any and all means of restoring, maintaining, or enhancing their visual and general welfare.
5. To maintain unselfish relationships with other members of the optometric profession as well as other disciplines for the benefit of our patients and the advancement of human knowledge and welfare.
6. To hold all patient information with highest confidentiality and privacy.
7. To serve our communities, country, and humankind as exemplary citizens in all aspects.

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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