

**NEW ORLEANS ACADEMY OF OPHTHALMOLOGY  
MEMBERSHIP APPLICATION**

***BASIC INFORMATION:***

Full Name \_\_\_\_\_ Date \_\_\_\_\_

Office Address \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ e-mail \_\_\_\_\_

Residence \_\_\_\_\_ Telephone \_\_\_\_\_

Place of Birth \_\_\_\_\_ Date of Birth \_\_\_\_\_ Citizenship (y or n) \_\_\_\_\_ Date \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Spouse's Name \_\_\_\_\_

How long have you been practicing in the current area? \_\_\_\_\_

***MEDICAL EDUCATION:***

Medical School \_\_\_\_\_ Degree \_\_\_\_\_ Dates \_\_\_\_\_

Internship: Hospital \_\_\_\_\_ Dates \_\_\_\_\_

Graduate Training Following Internship: Institution \_\_\_\_\_ Dates \_\_\_\_\_

Residencies \_\_\_\_\_ Dates \_\_\_\_\_

Or

Fellowships \_\_\_\_\_ Dates \_\_\_\_\_

Assistantships \_\_\_\_\_ Dates \_\_\_\_\_

Teaching Appointments \_\_\_\_\_ Dates \_\_\_\_\_

Postgraduate Education \_\_\_\_\_ Dates \_\_\_\_\_

Licensure: State or Province \_\_\_\_\_ Date \_\_\_\_\_

***PROFESSIONAL MEMBERSHIPS:***

Active \_\_\_\_\_ Associate \_\_\_\_\_ Parish/County Med. Society \_\_\_\_\_ Date \_\_\_\_\_

Fellow in American College of Surgeons \_\_\_\_\_ Date \_\_\_\_\_

Fellow in American Academy of Ophthalmology \_\_\_\_\_ Date \_\_\_\_\_

Board Certified \_\_\_\_\_ Date \_\_\_\_\_

Board Qualified \_\_\_\_\_ Date \_\_\_\_\_

Other Medical Societies \_\_\_\_\_ Date \_\_\_\_\_

Military Service \_\_\_\_\_ Date \_\_\_\_\_

Signed \_\_\_\_\_

**NOTE:** Please include a valid copy of your medical license and a \$75 check for the initiation fee.

New Orleans ophthalmologists must obtain two letters from Active Members.

An invoice for dues will be sent upon approval of application. Dues are \$475-575 per year.

This application should be sent to: 8131 Oak Street, Ste. 300 New Orleans, LA 70118 or fax to: 504-861-2549.