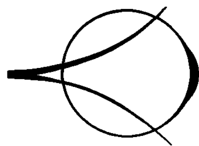

ILLINOIS SOCIETY OF EYE PHYSICIANS & SURGEONS

Metro Square One - Suite 120 ■ 10 W. Phillip Rd. ■ Vernon Hills IL 60061-1730
847/680-1666 ■ *Toll free:* 800/838-3627 ■ *Fax:* 847/680-1682
***E-mail:* Rich@RichardPaulAssociates.com ■ *Web:* www.ILeyeMD.org**

Combined Membership Application

Thank you for your interest in the Illinois Society of Eye Physicians & Surgeons. We certainly appreciate your participation in the organization and trust you will find it to be a beneficial experience. You may use this application for both the "practice" membership category, as well as the "individual" membership. Please follow these instructions for completing the application. Return it along with the appropriate dues payment to:

Illinois Society of Eye Physicians & Surgeons
10 W. Phillip Rd., Suite 120
Vernon Hills, IL 60061-1730

If you are paying your dues by credit card, you may fax your application to us at 847/680-1682 or save the document in PDF format and email to us at: Rich@RichardPaulAssociates.com
Questions? Call us at 800/838-3627

INSTRUCTIONS

PLEASE RETURN THE FOLLOWING 3 PAGES OF THIS APPLICATION
Please type or print!

❶ Step 1 – Membership Category (page 2)

✓ Determine the membership category that applies to you. The "practice" category provides membership to *all* ophthalmologists in your practice. It also includes certain additional benefits for the practice and your non-physician employees which are not available to individual members. The "individual" membership applies only to the single ophthalmologist joining, and member benefits are restricted to that person.

✓ Check the appropriate box to indicate the category of membership applied for and determine your dues. Practice members please note: If you have any ophthalmologists in your practice who are in their first, second or third year of practice, or semi-retired contact ISEPS office so we can apply the "new ophthalmologist" discount to your practice dues.

✓ Indicate your method of payment. If paying by check, make it out to "Illinois Society of Eye Physicians & Surgeons." If paying by Visa or MasterCard, enter your card number, expiration date and security code and be sure to sign where indicated.

❷ Step 2 – Practice information (page 3)

✓ Whether or not you are applying for the "practice" or "individual" category, please provide the information requested in this section. Data about the number of employees and number of ophthalmologists in your practice will be kept confidential. We use that only for our own planning purposes.

✓ Be sure to include the address and phone number for each office location. This information will enable us to refer patients to you. Use an additional sheet of paper, if necessary.

❸ Step 3 – Individual information (page 4)

✓ Please provide the information requested for each doctor in your practice applying for membership. If applying for the "practice" category, this would include all of your ophthalmologists. If an individual membership, then supply information only for that doctor. Copy this page as many times as necessary (one page per doctor).

Illinois Society of Eye Physicians & Surgeons Application

Applicant's name: ____

Practice: ____

Category of Membership and Dues Calculation

Membership Category

Practice Membership – If applying for a practice membership, check one of the following:

☐ **P1** - Solo doctor practice $575.00
☐ **P2** - Two doctor practice $1025.00
☐ **P3** - Three doctor practice $1,485.00
☐ **P4** - Four doctor practice $1,975.00
☐ **P5** - Five doctor practice $2,465.00
☐ **P6** - Six to eight doctors in the practice $2,925.00
☐ **P7** - Nine and more doctors in the practice $4,265.00

Practice Memberships are for the entire practice. It provides full membership for all ophthalmologists in the practice, as well as member benefits for non-physician employees and the practice itself. (Doctors in a practice membership do not also have to have an individual membership.) Dues are based on the number of ophthalmologists in the practice. Discounts available if any practice physicians qualify for categories Active 1, Active 2, Active 3 (see descriptions under individual category), or if any of your ophthalmologists are semi-retired.

Individual Membership – If you are applying for an individual membership, check the appropriate box:

☐ ***Active - $575.00*** Physicians actively engaged in the full-time practice of ophthalmology who have a valid Illinois medical license.
☐ ***Active 1 - $143.75*** Physicians in their *first year* of practice in ophthalmology who have a valid Illinois medical license.
☐ ***Active 2 - $287.50*** Physicians in their *second year* of practice in ophthalmology who have a valid Illinois medical license.
☐ ***Active 3 - $431.25*** Physicians in their *third year* of practice in ophthalmology who have a valid Illinois medical license.

Dues Payment

Enter the amount of your dues payment, based on membership category selected above . . . . $______

Form of payment: ❑ Check* ❑ Visa ❑ MasterCard ❑ Discover ❑ American Express

Make checks payable to "Illinois Society of Eye Physicians & Surgeons"

Credit Card # [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] Exp. Date [ ][ ] / [ ][ ]

Security Code (3 or 4 digits) [ ][ ][ ][ ]

Name on card: ____

Signature ____

Credit card billing address (if different from above): ______________________________

Billing address city/state/zip: ____

PRACTICE INFORMATION	
Full practice name	
<u>Primary</u> office street address	
City/State/Zip	
Other mailing address (i.e., P.O. Box) ***Include city/state/zip***	
Office Manager/Practice Administrator	
Office Phone (include area code)	
Office Fax (include area code)	
Practice E-mail address	
County (where primary office is located)	
Number of ophthalmologists in practice	
Type of Practice?	☐ Academic ☐ Large Group ☐ Small Group ☐ Solo ☐ Military/VA ☐ Multi-specialty clinic
Number of employees in your practice	
Does your practice have an optical dispensary?	☐ Yes ☐ No
Satellite Offices So that our referral service can be effective, please provide us with <u>all</u> of your office locations. This information will enable us to provide names of our members to prospective patients. List the street address, city, state, zip code and phone number. Feel free to use an additional sheet of paper if necessary.	Street Address City/State/Zip Phone # Street Address City/State/Zip Phone # Street Address City/State/Zip Phone #

INDIVIDUAL DOCTOR LISTINGS Copy this page and complete for each ophthalmologist	
Ophthalmologist's name Degree(s) - *check all that apply* AAO ID #___________	______________________________ ☐ MD ☐ DO ☐ PhD ☐ Other_______________
Preferred mailing address (check one)	☐ Office ☐ Home ☐ Alternate (PO Box)
Home street address (will not be published!)	
Home City/State/Zip	
Home Phone (Will not be published)	
Doctor's E-mail address	
Do you speak a foreign language? If yes, please list and whether you are fluent	☐ Yes ☐ No ______________________________ ☐ Fluent? ______________________________ ☐ Fluent?
Illinois medical license number	
Board certification(s) & date(s)	
Medical school & Year graduated	
Ophthalmology residency program(s) Location(s) & Dates	
Fellowship(s) completed Subspecialty, Location(s) & Date(s)	
Indicate your *primary* practice focus or subspecialty. Also, please note whether you perform refractive surgery. This information is an essential part of our patient referral service.	☐ I primarily practice general ophthalmology ***Subspecialties:*** ☐ Contact lenses ☐ Cornea/external diseases ☐ Glaucoma ☐ Neuro-ophthalmology ☐ Retina/vitreous ☐ Uveitis ☐ Pediatric care ☐ Ophthalmic pathology ☐ Low vision ☐ Plastic & reconstructive ☐ AIDS/HIV ☐ Oncology