



## ILLINOIS ASSOCIATION OF OPHTHALMOLOGY

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: RichardPaul@DLS.net

### ***Combined Membership Application***

Thank you for your interest in the Illinois Association of Ophthalmology. 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 Association of Ophthalmology  
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.

**Questions?** Call us at 800/838-3627 or send email to: RichardPaul@dls.net

### **INSTRUCTIONS**

PLEASE RETURN THE FOLLOWING 3 PAGES OF THIS APPLICATION

*Please type or print!*

#### **① 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 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 the IAO 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 Association of Ophthalmology." If paying by Visa or MasterCard, enter your card number, expiration date and security code and be sure to sign where indicated.

#### **② 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.

#### **③ 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).



**PRACTICE INFORMATION**

<b>Full practice name</b>	
<b><u>Primary</u> office street address</b>	
<b>City/State/Zip</b>	
<b>Other mailing address (i.e., P.O. Box)</b> <i>Include city/state/zip</i>	
<b>Office Manager/Practice Administrator</b>	
<b>Office Phone</b> (include area code)	
<b>Office Fax</b> (include area code)	
<b>E-mail address</b>	
<b>County</b> (where primary office is located)	
<b>Number of ophthalmologists in practice</b>	
<b>Type of Practice?</b>	<input type="checkbox"/> Academic <input type="checkbox"/> Large Group <input type="checkbox"/> Small Group <input type="checkbox"/> Solo <input type="checkbox"/> Military/VA <input type="checkbox"/> Multi-specialty clinic
<b>Number of employees in your practice</b>	
<b>Does your practice have an optical dispensary?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p align="center"><b>Satellite Offices</b></p> <p>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.</p> <p>Feel free to use an additional sheet of paper if necessary.</p>	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

<p style="text-align: center;"><b>Applicant's name</b> Degree(s) - <i>check all that apply</i> AAO ID # _____</p>	<p style="text-align: center;">_____</p> <p style="text-align: center;"><input type="checkbox"/> MD   <input type="checkbox"/> DO   <input type="checkbox"/> PhD   <input type="checkbox"/> Other _____</p>														
<p style="text-align: center;"><b>Home address</b> (will not be published!)</p>	<p style="text-align: center;">_____</p>														
<p style="text-align: center;"><b>Home address City/State/Zip</b></p>	<p style="text-align: center;">_____</p>														
<p style="text-align: center;"><b>Home Phone</b> (Will not be published)</p>	<p style="text-align: center;">_____</p>														
<p style="text-align: center;"><b>Doctor's E-mail address</b></p>	<p style="text-align: center;">_____</p>														
<p style="text-align: center;"><b>Do you speak a foreign language?</b>  If yes, please list and whether you are fluent</p>	<p style="text-align: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>_____ <input type="checkbox"/> Fluent?</p> <p>_____ <input type="checkbox"/> Fluent?</p> <p>_____ <input type="checkbox"/> Fluent?</p>														
<p style="text-align: center;"><b>Illinois medical license number</b></p>	<p style="text-align: center;">_____</p>														
<p style="text-align: center;"><b>Board certification(s) &amp; date(s)</b></p>	<p style="text-align: center;">_____</p>														
<p style="text-align: center;"><b>Medical school &amp; Year graduated</b></p>	<p style="text-align: center;">_____</p>														
<p style="text-align: center;"><b>Ophthalmology residency program(s) Location(s) &amp; Dates</b></p>	<p style="text-align: center;">_____</p>														
<p style="text-align: center;"><b>Fellowship(s) completed Subspecialty, Location(s) &amp; Date(s)</b></p>	<p style="text-align: center;">_____</p>														
<p>Indicate your <i>primary</i> practice focus or subspecialty. Also, please note whether you perform refractive surgery. This information is an essential part of our patient referral service.</p>	<p><input type="checkbox"/> I primarily practice <u>general ophthalmology</u></p> <p><b>Subspecialties:</b></p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Contact lenses</td> <td><input type="checkbox"/> Cornea/external diseases</td> </tr> <tr> <td><input type="checkbox"/> Glaucoma</td> <td><input type="checkbox"/> Neuro-ophthalmology</td> </tr> <tr> <td><input type="checkbox"/> Retina/vitreous</td> <td><input type="checkbox"/> Uveitis</td> </tr> <tr> <td><input type="checkbox"/> Pediatric care</td> <td><input type="checkbox"/> Ophthalmic pathology</td> </tr> <tr> <td><input type="checkbox"/> Low vision</td> <td><input type="checkbox"/> Plastic &amp; reconstructive</td> </tr> <tr> <td><input type="checkbox"/> AIDS/HIV</td> <td><input type="checkbox"/> Oncology</td> </tr> </table>	<input type="checkbox"/> Contact lenses	<input type="checkbox"/> Cornea/external diseases	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Neuro-ophthalmology	<input type="checkbox"/> Retina/vitreous	<input type="checkbox"/> Uveitis	<input type="checkbox"/> Pediatric care	<input type="checkbox"/> Ophthalmic pathology	<input type="checkbox"/> Low vision	<input type="checkbox"/> Plastic & reconstructive	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Oncology		
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