



Michigan Society of Eye Physicians and Surgeons

ADMINISTRATIVE OFFICE

120 W. Saginaw - East Lansing, MI 48823

517-333-6739 - FAX 517-336-5797

APPLICATION FOR MEMBERSHIP

I hereby apply for membership in the Michigan Ophthalmological Society, and agree to support its Constitution and Bylaws, and the principles and medical ethics which have been or may from time to time hereafter be adopted by the American Medical Association.

Name (as you would like it to appear on records and correspondence):

_____ MD DO
(First) (Middle) (Last)

MEDICAL EDUCATION

School _____ Graduation Date _____

Degree _____ Certifications _____

School _____ Graduation Date _____

Degree _____ Certifications _____

Internship _____

Post-Graduate Residency _____

Fellowship _____

Subspecialty _____ Year you started practicing after residency _____

ABO Certified Yes No

Name of practice or employer _____

Work address _____

Work Phone (____) _____ (street) (City) (State) (Zip) (County)
FAX (____) _____ (where you prefer to receive MOS faxes)

Email Address: _____ @ _____

How do you prefer to receive MOS communications? fax email mail (check all that apply) at work at home

PREVIOUS PRACTICE or EMPLOYMENT

Location _____ Date _____

Michigan Medical License Number _____

Michigan State Medical Society member yes no

County Medical Society member yes no

Home address _____
(Street) (City) (State) (Zip) (County)

Home Phone (____)____-_____ (optional)

US Congressional District Home _____ Work _____

MI Senate District Home _____ Work _____

MI House of Representatives Home _____ Work _____

Date of Birth _____ Spouse's Name _____

Please attach a CV or biographical sketch.

How would you like to be involved in MOS? Please check all that apply:

- ____ Officer position
- ____ Board member
- ____ Young Ophthalmologists
- ____ Membership committee
- ____ Educational committee
- ____ Legislative issues committee
- ____ Third-party payer committee
- ____ Member Benefits committee
- ____ OPAC committee
- ____ Finance committee
- ____ Speaker
- ____ Other

Please provide the names, phone numbers, and addresses of two licensed practicing **MSEPS members** as references:

Name: _____

Address: _____

Phone (____)____-_____

Name: _____

Address: _____

Phone (____)____-_____

Who recruited you into membership? _____

Signature

Date

Please include your **check** payable to Michigan Ophthalmological Society in the amount of:

\$150 if your first year in practice

\$350 if your second year in practice

\$550 if two or more years in practice

No Charge for Resident or Fellow

OR:

Credit Card payment: Visa MC Discover

Card # _____/_____/_____/_____

Expiration Date _____/_____

Expected grad. Date _____