



# 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 \_\_\_\_\_