American Association for Pediatric Ophthalmology and Strabismus

American Association for Pediatric Ophthalmology and Strabismus

Active Membership Application	
1. PERSONAL INFORMATION 01-00	
First Name & Middle Initial * 01-01	
Last Name * 01-02	
Credential Example: MD, PhD, MBA, etc.* 01-03	
Email Please note: An acknowledgement of this application will be sent by email to the above address. This entry must be accurate; otherwise, no acknowledgement will be received.* 01-04	
2.PRIMARY OFFICE ADDRESS 02-01	
Office/Clinic/Institution* 02-02	
Office Street Address * 02-03	
Address, line 2 02-04	
City * 02-05	
State * 02-06	
Zip Code * 02-07	
Country * 02-08	
Office Phone (Please include area code / country code)* 02-09	
Office Fax (Please include area code / country code) 02-10	
Cell / Mobile (Please include area code / country code) 03-00	
3. MEDICAL LICENSE INFORMATION 03-01	
Do you have a valid Medical License?* 03-02	○ Yes ○ No

SAMPLE

Medical License Number* 03-03	
State/Province * 04-00	
4. PROFESSIONAL AFFILIATION 04-01	
You MUST be certified by one of these organizations. Please select your professional certification. * 04-02	○ American Board of Ophthalmology ○ American Osteopathic Association ○ Royal College of Physicians and Surgeons of Canada
You must be a fellow or member in good standing as one of the following. Please select your membership.* 05-00	○ Active Fellow of American Academy of Ophthalmology ○ Member of the Canadian Ophthalmological Society ○ Member of the American Osteopathic Colleges of Ophthalmology & Otorhinolaryngology, Head and Neck Surgery.
5. Professional Information & References 05-01	
College / University* 05-02	
Start Date (month-year)* 05-03	Month: Year:
End Date (month-year)* 05-05	Month: Year:
College / University 05-07	
Start Date (month-year) 05-08	Month: Year:
End Date (month-year) 05-10	Month: Year:
Medical or Osteopathic School * **05-12**	
Start Date (month-year)* 05-13	Month: Year:
End Date (month-year)* 05-15	Month: Year:
Internship * **05-17**	
Start Date (month-year)* 05-18	Month: Year:
End Date (month-year)* 05-20	Month: Year:
Residency * **05-22**	
Start Date (month-year)* 05-23	Month: Year:
End Date (month-year)* 05-25	Month: Year:
Fellowship Training Requirements. Please select your fellowship training:* 05-27	○ I have completed one year of fellowship training in pediatric ophthalmology and/or strabismus under direction of an AAPOS Member (for fellowships completed in 1996 or earlier) ○ I have satisfactorily completed an AAPOS approved fellowship program (for fellowships completed after 1996 and before 2006) ○ I have satisfactorily completed an Association of University Professors in Ophthalmology Fellowship Compliance Committee compliant fellowship in 2006 or later
Fellowship * 05-28	
Start Date (month-year)* 05-29	Month: Year:
End Date (month-year)* 05-31	Month: Year:

SAMPLE

Was this position under the direction of an AAPOS/AUPO approved program?* 05-33	○ Yes ○ No
References	
Fellowship Director * 05-34	
Fellowship Director Email Address * 05-35	
Name of a full AAPOS Member reference other than Fellowship Director * 05-36	
E-mail address of full AAPOS Member reference other than Fellowship Director * 05-37	
Percentage of practice related to pediatric ophthalmology and/or strabismus: * 07-01	
Signature 08-00	
☐ I understand my responsibilities as an applicant. I have reviewed my application and have provided accurate information. * 08-01	
Please enter your email address a 2nd time. It must match the address you entered in Question 01-04* 08-02	
Submit	Submit = You will have the opportunity to review and edit your form entries.

Copyright © 2010 American Association for Pediatric Ophthalmology and Strabismus

SAMPLE