



American Association for Pediatric Ophthalmology and Strabismus

Associate Path C Membership Application	
1. PERSONAL INFORMATION 01-00	
First Name & Middle Initial * 01-01	<input type="text"/>
Last Name * 01-02	<input type="text"/>
Credential Example: MD, PhD, MBA, etc.* 01-03	<input type="text"/>
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	<input type="text"/>
2. PRIMARY OFFICE ADDRESS 02-01	
Office/Clinic/Institution* 02-02	<input type="text"/>
Office Street Address * 02-03	<input type="text"/>
Address, line 2 02-04	<input type="text"/>
City * 02-05	<input type="text"/>
State * 02-06	<input type="text"/>
Zip Code * 02-07	<input type="text"/>
Country * 02-08	<input type="text"/>
Office Phone (Please include area code / country code)* 02-09	<input type="text"/>
Office Fax (Please include area code / country code) 02-10	<input type="text"/>
Cell / Mobile (Please include area code / country code) 03-00	<input type="text"/>
3. MEDICAL LICENSE INFORMATION 03-01	
Do you have a valid Medical License?* 03-02	<input type="radio"/> Yes <input type="radio"/> No

Medical License Number* 03-03	<input type="text"/>
State/Province* 04-00	<input type="text"/>
4. PROFESSIONAL AFFILIATION 04-01	
You MUST be certified by one of these organizations. Please select your professional certification.* 04-02	<input type="radio"/> American Board of Ophthalmology <input type="radio"/> American Osteopathic Association <input type="radio"/> 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	<input type="radio"/> Active Fellow of American Academy of Ophthalmology <input type="radio"/> Member of the Canadian Ophthalmological Society <input type="radio"/> Member of the American Osteopathic Colleges of Ophthalmology & Otorhinolaryngology, Head and Neck Surgery.
5. Professional Information & References 05-01	
College / University* 05-02	<input type="text"/>
Start Date (month-year)* 05-03	Month: <input type="text"/> Year: <input type="text"/>
End Date (month-year)* 05-05	Month: <input type="text"/> Year: <input type="text"/>
College / University 05-07	<input type="text"/>
Start Date (month-year) 05-08	Month: <input type="text"/> Year: <input type="text"/>
End Date (month-year) 05-10	Month: <input type="text"/> Year: <input type="text"/>
Medical or Osteopathic School* 05-12	<input type="text"/>
Start Date (month-year)* 05-13	Month: <input type="text"/> Year: <input type="text"/>
End Date (month-year)* 05-15	Month: <input type="text"/> Year: <input type="text"/>
Internship* 05-17	<input type="text"/>
Start Date (month-year)* 05-18	Month: <input type="text"/> Year: <input type="text"/>
End Date (month-year)* 05-20	Month: <input type="text"/> Year: <input type="text"/>
Residency* 05-22	<input type="text"/>
Start Date (month-year)* 05-23	Month: <input type="text"/> Year: <input type="text"/>
End Date (month-year)* 05-25	Month: <input type="text"/> Year: <input type="text"/>
I did not complete a fellowship training program but have five years in practice consisting of at least 50% pediatric ophthalmology and/or strabismus 05-27	<input type="radio"/> Yes <input type="radio"/> No
Where was your 5 years of practice, of which at least 50% consisted pediatric ophthalmology and/or strabismus? 05-28	<input type="text"/>
Start Date (month-year)* 05-29	Month: <input type="text"/> Year: <input type="text"/>

End Date (month-year)* 05-31	Month: <input type="text"/> Year: <input type="text"/>
Name of first AAPOS member reference * 05-34	<input type="text"/>
E-mail address of first AAPOS Member reference * 05-35	<input type="text"/>
Name of second AAPOS member reference * 05-36	<input type="text"/>
E-mail address for second AAPOS Member reference * 05-37	<input type="text"/>
6. PROFESSIONAL EXPERIENCE 06-00	
Years and months Professional Experience after last formal training.* 06-01	Years: <input type="text"/> Months: <input type="text"/>
7. PRACTICE COMPOSITION 07-00	
Percentage of practice related to pediatric ophthalmology and/or strabismus: * 07-01	<input type="text"/>
Please describe your significant commitment to the field of pediatric ophthalmology and strabismus. * 07-02	
<input type="text"/>	
Signature 08-00	
<input type="checkbox"/> 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	<input type="text"/>
Submit	<input type="button" value="Submit"/> = You will have the opportunity to review and edit your form entries.