



American Association for Pediatric Ophthalmology and Strabismus

International Path D 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 02-00	
Office/Clinic/Institution* 02-01	<input type="text"/>
Office Street Address * 02-02	<input type="text"/>
Address, line 2 02-03	<input type="text"/>
City * 02-04	<input type="text"/>
State * 02-05	<input type="text"/>
Zip Code * 02-06	<input type="text"/>
Country * 02-07	<input type="text"/>
Office Phone * (Please include area code / country code) 02-08	<input type="text"/>
Office Fax (Please include area code / country code) 02-09	<input type="text"/>
Cell / Mobile (Please include area code / country code) 02-10	<input type="text"/>
3. MEDICAL LICENSE INFORMATION 03-00	
Do you have a valid Medical License?* 03-01	<input type="radio"/> Yes <input type="radio"/> No

Medical License Number 03-02	<input type="text"/>
Country * 03-03	<input type="text"/>
4. Professional Information & References 04-00	
Medical or Osteopathic School * 04-01	<input type="text"/>
Start Date (month-year) * 04-02	Month: <input type="text"/> Year: <input type="text"/>
End Date (month-year) * 04-04	Month: <input type="text"/> Year: <input type="text"/>
Internship 04-06	<input type="text"/>
Start Date (month-year) * 04-07	Month: <input type="text"/> Year: <input type="text"/>
End Date (month-year) * 04-09	Month: <input type="text"/> Year: <input type="text"/>
Residency * 04-11	<input type="text"/>
Start Date (month-year) * 04-12	Month: <input type="text"/> Year: <input type="text"/>
End Date (month-year) * 04-14	Month: <input type="text"/> Year: <input type="text"/>
Fellowship * 04-16	<input type="text"/>
Was this position under the direction of an AAPOS Member: * 04-17	<input type="radio"/> Yes <input type="radio"/> No
Start Date (month-year) * 04-18	Month: <input type="text"/> Year: <input type="text"/>
End Date (month-year) * 04-20	Month: <input type="text"/> Year: <input type="text"/>
Fellowship Director * 04-22	<input type="text"/>
Fellowship Director Email Address * 04-23	<input type="text"/>
Name of a full AAPOS Member reference other than Fellowship Director * 04-24	<input type="text"/>
E-mail address of full AAPOS Member reference other than Fellowship Director * 04-25	<input type="text"/>
5. PROFESSIONAL EXPERIENCE 05-00	
Years and months Professional Experience after last formal training. * 05-01 & 05-02	Years: <input type="text"/> Months: <input type="text"/>
6. PRACTICE COMPOSITION 06-00	
Percentage of practice related to pediatric ophthalmology and/or strabismus: * 06-01	<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

Submit

= You will have the opportunity to review and edit your form entries.

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