



American Association for Pediatric Ophthalmology and Strabismus

Orthoptist 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: CO, COT, COT MD 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. CERTIFICATION INFORMATION 03-00	

Certifying Body (AOC/COC/IOA) * <small>03-01</small>	<input type="radio"/> American Orthoptic Council <input type="radio"/> Canadian Orthoptic Council <input type="radio"/> International Orthoptic Council
Are you an orthoptist in a country with full membership status in IOA? * <small>03-02</small>	<input type="radio"/> Yes <input type="radio"/> No
Please note: a letter will be sent to the AOC, COC, or IOA to verify your information.	
4. Professional Information & References <small>04-00</small>	
College / University* <small>04-01</small>	<input type="text"/>
Start Date (month-year) * <small>04-02</small>	Month: <input type="text"/> Year: <input type="text"/>
End Date (month-year) * <small>04-04</small>	Month: <input type="text"/> Year: <input type="text"/>
College / University <small>04-06</small>	<input type="text"/>
Start Date (month-year) <small>04-07</small>	Month: <input type="text"/> Year: <input type="text"/>
End Date (month-year) <small>04-09</small>	Month: <input type="text"/> Year: <input type="text"/>
Location of Training Center* <small>04-11</small>	<input type="text"/>
References	
Name of a full AAPOS Member Ophthalmologist reference who will support your application * <small>04-12</small>	<input type="text"/>
E-mail Address of AAPOS Member Ophthalmologist supplying reference * <small>04-13</small>	<input type="text"/>
Signature <small>08-00</small>	
<input type="checkbox"/> I understand my responsibilities as an applicant. I have reviewed my application and have provided accurate information. * <small>08-01</small>	
Please enter your email address a 2nd time. It must match the address you entered in Question 01-04 * <small>08-02</small>	<input type="text"/>
Submit	<input type="button" value="Submit"/> = You will have the opportunity to review and edit your form entries.