

# Colorado Optometric Association

*Affiliated with the American Optometric Association*

1600 Broadway • Suite 1320 • Denver, CO 80202

Tel: 303.863.9778 • Fax: 303.863.9775 • E-mail: coa@visioncare.org • Toll Free: 1.877.691.2095

## Application for Partial Practice Membership

**NOTE: If you are a current COA member changing to Partial Practice status, you need only complete the Certification of Eligibility for Partial Practice form and fax to 303.863.9775 or mail to COA at the address listed above.**

**Please do not send dues to the COA unless you receive a statement. Monthly dues statements will be mailed following COA Board approval of your application.**

### Part I: Personal Data: (Please print or type)

Name \_\_\_\_\_  
Last First Middle

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Children's Names \_\_\_\_\_

Place of Birth \_\_\_\_\_ Date of Birth \_\_\_\_\_ Dates of Military Service \_\_\_\_\_

### PLEASE CHECK ONLY ONE AS YOUR PREFERRED MAILING ADDRESS!

**Principal Office Address:** \_\_\_\_\_  
Practice Name Address  
City State Zip Phone ( \_\_\_\_ ) \_\_\_\_\_

**Second Office Address:** \_\_\_\_\_  
Practice Name Address  
City State Zip Phone ( \_\_\_\_ ) \_\_\_\_\_

**Home Address:** \_\_\_\_\_  
Address  
City State Zip Phone ( \_\_\_\_ ) \_\_\_\_\_

Indicate area(s) of interest or practice:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Contact Lens        | <input type="checkbox"/> Children's Vision | <input type="checkbox"/> Deaf Patients         | <input type="checkbox"/> Electrodiagnosis |
| <input type="checkbox"/> General Practice    | <input type="checkbox"/> Holistic Care     | <input type="checkbox"/> Home Exams            | <input type="checkbox"/> Headache Therapy |
| <input type="checkbox"/> Industrial Safety   | <input type="checkbox"/> Industrial Vision | <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Low Vision       |
| <input type="checkbox"/> Optical Photography | <input type="checkbox"/> Orthokeratology   | <input type="checkbox"/> Public Health         | <input type="checkbox"/> Pilot's Vision   |
| <input type="checkbox"/> Special Problems    | <input type="checkbox"/> Sports Vision     | <input type="checkbox"/> Vision Therapy        |   |

Original license (in any state) received: \_\_\_\_\_  
Month Year

Other State Licenses Held:	1.	2.	3.	4.
Languages Spoken: (other than English)	1.	2.	3.	4.

Has your optometry association membership ever been suspended?  Yes  No

**Part II: Education**

Pre-optometric School	Number of Years or Year of Graduation	Degree	School/College of Optometry	Graduation Year or Expected (Actual)	Degree

Residency?  Yes  No

Where:

Date:

Honorary Degree:

Honorary Societies:

Are you currently a member of the COA?  Yes  No

Membership in other optometric/scientific societies	Membership in civic, service & community organizations

The undersigned desires to become a Partial Practice member of the Colorado Optometric Association and agrees to abide by the Bylaws of the Association if this application is accepted.

I hereby certify and represent that I have completed the Certificate of Eligibility for Partial Practice Membership form and submitted the form along with my completed Application for Partial Practice Membership form. Failure to report any change in status may result in immediate forfeiture of Association membership. I understand that the COA reserves the right to request verification of this information at any time.

Date \_\_\_\_\_ Signature of Applicant \_\_\_\_\_