

# Colorado Optometric Association

*Affiliated with the American Optometric Association*

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## Membership Application

### Part I: Membership Classification: *(Please check only one)*

- Active** a qualified optometrist residing in Colorado and licensed in Colorado. (Note: If practicing 24 hours per week or less, please request a partial practice application.)
- Associate** an optometrist who is licensed and practicing optometry in other states of the United States, territories of the United States or foreign countries **and** is a member in good standing of the American Optometric Association.
- Federal Services** optometrist in active duty in the Armed Forces or in the commissioned corps of the United States Public Health Service or full-time employee of the Veteran's Administration or other federal government entity and stationed in Colorado. (Note: If you are not stationed in Colorado, please apply for Associate membership.)
- Special** an optometrist residing in Colorado who is not engaged in the industrial, clinical or private practice of optometry and not in federal service.
- Student/ Post Grad** A person working toward a doctor of optometry degree, or currently in an approved optometric residency program, or a fellow in an approved advanced study program of optometry. Postgraduates must have completed the AOA postgraduate membership form.

### Part II: Application Information: *(Please print or type)*

**PLEASE CHECK ONLY ONE PREFERRED MAILING ADDRESS.**

Name \_\_\_\_\_  
*Last First Middle Nickname*

**Principal Office Name:** \_\_\_\_\_

**Principal Office Address:** \_\_\_\_\_  
*Street Address and /or P.O. Box*

\_\_\_\_\_  
*City County ST Zip+4*

\_\_\_\_\_  
*Phone Toll Free Number Fax E-mail*

**Second Office Name:** \_\_\_\_\_

**Second Office Address:** \_\_\_\_\_  
*Street Address and /or P.O. Box*

\_\_\_\_\_  
*City County ST Zip+4*

\_\_\_\_\_  
*Phone Toll Free Number Fax E-mail*

**Home Address:** \_\_\_\_\_  
*Street Address and /or P.O. Box Spouse*

\_\_\_\_\_  
*City County ST Zip+4*

\_\_\_\_\_  
*Phone Toll Free Number Fax E-mail*

*(Continued)*

**Part II, continued: Application Information: (Please print or type)**

Pre-optometric School	Number of Years or Year of Graduation	Degree	School/College of Optometry	Graduation Year	Degree
Residency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Where: _____		
Hospital Privileges?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Where: _____		
AOA Member?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Number: _____		
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth: _____		
Has your license ever been suspended?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Has your optometry association membership ever been suspended?	<input type="checkbox"/> Yes		<input type="checkbox"/> No		
Original license (in any state) received: _____ <i>Month</i> <i>Year</i>					
Other State Licenses Held:	1. _____	2. _____	3. _____	4. _____	
Languages Spoken: (other than English)	1. _____	2. _____	3. _____	4. _____	
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			

The undersigned desires to become a member of the Colorado Optometric Association and agrees to abide by the Bylaws of the Association upon acceptance.

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