ILLINOIS OPTOMETRIC ASSOCIATION

304 West Washington Street • Springfield, Illinois 62701
217-525-8012 • Fax 217-525-8018
www.ioaweb.org • ioa@ioaweb.org

Membership Application

Please Print

First Name: _____ Middle (Initial): _____ Last: _____

Maiden Name: _____ Birth Date: _____/_____/_____ M □ F □

Home Address: _____

_____

Phone: (_____) _____ Cell: (_____) _____

E-mail: (PRINT VERY CLEARLY)_____

Main Office Address: (Include company name and suite if applicable)_____

_____

Phone: (_____) _____ Fax: (_____) _____

E-mail: (PRINT VERY CLEARLY)_____

Alternate Office Address: (if applicable)_____

_____

Phone: (_____) _____ Fax: (_____) _____

Send mail to (check one):

□ Main Office □ Home Address

Send email to (check one):

□ Main Office □ Home Address

Local Society Affiliation (check one)**:**

□ Society closest to my main office □ Society closest to my home

(Continue on the back)

Licensing Information:

Year of original licensure (regardless of state): _____ State of original licensure: _____

Other states currently licensed in: _____

Illinois License Number: **0 4 6 -** _____ (write "pending" if applicable)

School of Optometry:_____ Year of graduation:_____

Did you complete a residency? □ YES □ NO If yes, date of completion: _____

If yes, place of residency: _____

Other Degrees: _____

Other Information:

Did someone encourage you to join the IOA? □ YES □ NO

If yes, please provide their name: _____

Areas of Practice:

The IOA receives requests from persons looking for an optometrist in their geographic area or needed practice. Please indicate your areas of practice:

□ Child Exams
□ Contacts
□ Geriatric Exams
□ Glaucoma
□ Home Exams
□ InfantSEE
□ Low Vision
□ Medicaid Exams
□ Medicaid Glasses
□ Medicare
□ Nursing Home Exams
□ Ortho K
□ Spanish Speaking
□ Other Language(s)_____
□ Sports Vision
□ Vision Therapy
□ Vision USA
□ Other Services_____

I certify that I am licensed to practice optometry in the state of Illinois. I further certify that, upon acceptance into membership, I will fully support the Constitution and Bylaws and Code of Ethics of both the Illinois Optometric Association and the American Optometric Association. I understand should I violate these in any way my membership will be subject to termination.

Signature: _____ Date: _____

Please return to: Illinois Optometric Association
304 W Washington St
Springfield IL 62701-1119

or FAX to 217-525-8018

Questions? Call 217-525-8012
or 800-933-7289
or email ioa@ioaweb.org