Mississippi Academy
of Eye Physicians and Surgeons

Membership Application

Name: _____

Mailing Address: _____
P. O. Box or Street City State/Zip

Home Address: _____
Street City State/Zip

Telephone: _____

Office: _____

Cell: _____

Residence: _____

Fax: _____

E-mail address: _____

Education and Training
Undergraduate School: _____

Medical School: _____

Membership Category (Check one)

Signed _____

__ Regular $750/Yr.

__Semi-Retired $375/Yr. Date _____

__Resident – Free

Post Office Box 217 • Jackson, Mississippi 39205-0217 • 601-353-0559
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