



the
Texas Optometric Association, Inc.
Membership Application

Date _____ Referred by: _____

(Please print or type)

Please check preferred mailing address: Home Business

Preferred method of contact by AOA: Regular mail E-mail

Last Name _____ First Name _____ Initial _____

Maiden Name, If Applicable _____

Date of Birth ____/____/____

Sex: M F

Home Address _____

City _____ State _____ Zip _____ County _____

Home Phone () _____

Email _____ Spouse _____

Office Address _____

City _____ State _____ Zip _____ County _____

Office Phone () _____ FAX () _____

Days in Office (please circle) S M T W T F S Approximate number of hours worked per week: ____

License Number _____ Year Licensed _____ State _____

License Number _____ Year Licensed _____ State _____

Optometry School _____

Yr. Graduated _____ Residency: Yes No If yes, Yrs. completed _____ to _____

Student Member of TOA Yes _____ No _____ If yes, give dates _____ to _____

A **new licensee** is entitled to an ascending dues structure based on the year of original licensure. A **member** who has achieved full dues status with AOA is considered a full active member of the Texas Optometric Association. **Payments to TOA are not deductible as charitable contributions for Federal Income Tax purposes. However, they may be deductible under other provisions of the Internal Revenue Code.**

"As a member of the Texas Optometric Association, I promise to support the Constitution and Bylaws of this Association and to always do my best to uphold the interests of the profession."

Signed _____ Date _____

Please return to: **Texas Optometric Association**
1104 West Avenue
Austin, TX 78701
Fax: 512-326-8504

Name _____

This questionnaire helps us keep you better informed and our records complete.
Thank you for completing this form. Please type or print.

PRACTICE INFORMATION

Have you ever been accepted for membership in AOA through another state? Yes ___ No ___

Primary Office

Address _____ P.O. Box# _____

City _____ State _____ Zip _____ County _____

Office Phone () _____ Days in Office (please circle) S M T W T F S

Branch Office

Address _____ P.O. Box# _____

City _____ State _____ Zip _____ County _____

Office Phone () _____ Days in Office (please circle) S M T W T F S

List any former practice locations (states) _____

TPA Certified: Yes ___ No ___

Type of Practice: Solo _____ Partnership _____ Group _____
Other _____

Office: Dispensary: Yes ___ No ___ Laboratory: Yes ___ No ___

Hospital Affiliate: Yes ___ No ___ If Yes, Where? _____

Specialty: VT ___ Contact Lens ___ Low Vision ___ Pediatric ___ Geriatric ___ Sports Vision ___

Other _____

FAMILY INFORMATION

Spouse _____ Occupation _____

Children Names & Birth Dates _____

Optometric Relatives: _____

POLITICAL INFORMATION

State House District _____ State Representative _____

State Senate District _____ State Senator _____

Political Party _____ Congressional District _____

Note: If an elected official is your patient, your friend, relative, etc., please make a note:
