Save (then e-mail) Print Form

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_TX___Zip_____County_____

Home Phone ( ) _____

Email_____Spouse_____

Office Address_____

City_____State_TX___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_TX_Zip_____County_____

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

Branch Office

Address _____P.O. Box#_____

City_____State_TX_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:

_____