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| **2021**  **APPLICATION**  **FOR**  **POST GRADUATE**  **MEMBERSHIP**  **\_\_\_\_\_\_\_\_\_\_\_**  **RETURN COMPLETED APPLICATION BY MAIL OR EMAIL TO:**  American Optometric  Association  ATTN: Dues Accounting  243 N. Lindbergh Blvd, Floor 1  St. Louis, MO 63141  Phone: 800.365.2219  Email: DuesAccounting@aoa.org  **\_\_\_\_\_\_\_\_\_\_\_**  PLEASE NOTE:  *This application is for:*  **NEW, REINSTATED, AND TRANSFERRING POST GRADUATE MEMBERS.**  *Current members requesting a change in classification to Post Graduate must be submitted using the* ***Notification of Change form during the open enrollment period of January 1 through April 30\*.*** *The approved form will be returned upon processing.*  \*If the April 30 deadline falls on a weekend, the deadline is extended to the first Monday following the deadline. | **AFFILIATE OFFICE USE ONLY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Affiliate Association:** | | | | | | | | | | | | | | | |  | | | | | | | | | | | **Prepared By:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Date:** | | |  | | |
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| **Comments:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **MEMBERSHIP INFORMATION**  Member is: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| First Name: | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| Middle Initial: | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
| Last Name: | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
| Suffix (Jr., Sr., etc.): | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | Designations (OD, PhD, etc.): | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
| Former / Maiden Name: | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
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| **CONTACT & DEMOGRAPHIC INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Preferred Mailing Address:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | Home  Business | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Home Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | City: | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | State: | | | | | | | | |  | | | | | | Zip: | | | | | | | | |  | | | | | | | |
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| Business / Practice Name: | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Business Address: | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Gender: | | | | | | | | | Male | | | | | | | | | | | | | | | Female | | | | | | | | Choose Not to Disclose | | | | | | | | | | | | | | | | | | | | | | | | | Date of Birth: | | | | | | | | | |  | | | |
| Marital Status: | | | | | | | | | | | | | | | Single | | | | | | | | | | | | | | Married | | | | | | | | | | | | | | | | Divorced | | | | | | | | | | | | | Widowed | | | | | | | | | mm / dd / yyyy | | | |
|  | | |  | | | | | | | | | | | | Partner | | | | | | | | | | | | | | Unknown | | | | | | | | | | | | | | | | Choose Not to Disclose | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Name of Spouse: | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| Ethnicity / Race: | | | | | | | | | | | | | | | | | | | | Hispanic / Latino origin? | | | | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | | | | | | | | | | | and / or | | | | | | | | |
|  | | | | White | | | | | | | | | Black / African-American | | | | | | | | | | | | | | | | | | | | | | | Asian | | | | | | | | | | | | | | Native American | | | | | | | | | | | | | | | |  | | | | |
|  | | | | | Alaska Native / Pacific Islander | | | | | | | | | | | | | | | | | | | | | | | | | | Other | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| NPI Number: | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Military Service: | | | | | | | | | | |
| Branch: | | | | | | | | | | |
| Army | Marine Corps | | | Navy | | Air Force | | Coast Guard | | National Guard |
| Status: | |  | | | | | | | | |
| Active | | | Inactive | | Reserves | | Retired | |  | |

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| Optometry School Attended: | |  | | | | Year of Graduation: | |  |
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| Licenses Obtained: | State: | |  | Year: |  | |  | |
|  | State: | |  | Year: |  | |  | |
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| **VERIFICATION OF POST GRADUATE STATUS** | | | | | | | | |

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| *It is the affiliate’s responsibility to obtain verification from the school or college of the member’s post graduate status. The application cannot be processed with missing or incomplete verification information.* **THIS INFORMATION IS REQUIRED TO PROCESS THIS APPLICATION.** | | | | | |
| SCHOOL AFFILIATION: | |  | | | |
| RESIDENCY SITE NAME: | |  | | | |
| RESIDENCY CITY / STATE: | |  | | | |
| RESIDENCY BEGIN DATE (MONTH/YEAR): | |  | | | |
| RESIDENCY END DATE (MONTH/YEAR): | |  | | | |
| CURRENT RESIDENCY, INTERNSHIP OR GRADUATE PROGRAM: | | | |  | |
| Brain Injury | Family Practice | | Low Vision Rehab | | Primary Eye Care |
| Community Health | Geriatric Optometry | | Ocular Disease | | Refractive Surgery |
| Cornea & Contact | Hospital Based Care | | Pediatric Optometry | | Vision Therapy & Rehab |
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| **ANNUAL DUES OBLIGATION** | | | |
| **Dues schedule can be found at bottom of Application.**  *No method of proration other than monthly as listed on the dues schedule is allowed. Members who have dropped and reinstated membership in the same calendar year with the same affiliate must pay* ***full year dues****.* | | | |
| Effective Month of Membership |  | Annual Dues: | $ |

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| **AOA OFFICE USE ONLY** | | | | | | | | | | |
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| AOA ID Number: | | | |  | | Processed by: | |  | Date: |  |
| Dues Assessed: | | | | | $ | |  | | | mm / dd / yyyy |
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| **2021 ANNUAL DUES OBLIGATION SCHEDULE** |

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|  | **JANUARY** | **FEBRUARY** | **MARCH** | **APRIL** | **MAY** | **JUNE** |
| **Post Graduate Member** | $35.00 | $32.08 | $29.17 | $26.25 | $23.33 | $20.41 |

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|  | **JULY** | **AUGUST** | **SEPTEMBER** | **OCTOBER** | **NOVEMBER** | **DECEMBER** |
| **Post Graduate Member** | $17.50 | $14.59 | $11.67 | $8.74 | $5.83 | $2.92 |