



# Palm Beach County Ophthalmology Society, Inc. Application for Membership

Date: \_\_\_\_\_

Name: \_\_\_\_\_ MD / DO / PHD (circle all that apply)

Practice Name: \_\_\_\_\_

Business Address: \_\_\_\_\_

City: \_\_\_\_\_ State: FL Zip: \_\_\_\_\_

Business Phone #: \_\_\_\_\_ FAX #: \_\_\_\_\_

E-mail Address \_\_\_\_\_ (Required)

Home Phone # \_\_\_\_\_ Your date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Spouse's name \_\_\_\_\_

Web Site address: http://www.\_\_\_\_\_

American Board of Ophthalmology Certified? NO / YES - Date: MO\_\_\_\_YR\_\_\_\_

Residency: \_\_\_\_\_

MO-YR of Graduation: \_\_\_\_\_

Fellowships:

\_\_\_\_\_  
\_\_\_\_\_

Specialize in: \_\_\_\_\_

\_\_\_\_\_

As a member you have a professional business listing on the society web site; would you like your e-mail address included in the listing: YES / NO

Signature \_\_\_\_\_

I hereby acknowledge that all information is true and correct and permit the above information to be used by the Palm Beach Ophthalmology Society, Inc. as needed for membership purposes. Note: We do not share any information with any outside sources or other members. Membership is for a calendar year and dues are \$125.00 per year.

Please Mail this completed application and your check for Membership Dues of \$125.00 (made payable to Palm Beach County Ophthalmology Society, Inc.) for the year to:

Palm Beach County Ophthalmology Society, Inc.  
P.O. Box 32264  
Palm Beach Gardens, FL 33420-2264