

Do you have a specialty and if so what area?_

2016 MEMBERSHIP APPLICATION

Being a licensed Optometrist interested in the further professional and scientific advancement of my profession, and being in accord with the purpose and objectives of the Georgia Optometric Association, I do hereby apply for GOA Membership.

Please Print Application Date: Date					
Twee series of the content of the	Please Print Application			Date:	
Twee series of the content of the	□ New Member □ Reinstate Membe	r □ State Transfer	□ Current AOA M		
Cook Member Name Cook Name C	I was referred to membership by:				
Name: (Last) (First) (Middle) n Female Marital Status: d Single d Married Name of Spouse (if applicable): ((If your spouse is an OPTOMETRIST, list his/her full professional name) HOME ADDRESS Home Address: (City: State: Zip Code:	- Was released to mornisoronip by	(9	GOA Member Name)		•
Date of Birth:	PERSONAL INFORMATION				
Date of Birth: Date in Married Name of Spouse (if applicable): (If your spouse is an OPTOMETRIST, list his/her full professional name) HOME ADDRESS Home Address: City: State: Zip Code:	Name:	(Eirof)	(Middle)		
HOME ADDRESS		(FIFSt)		□ Female	
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City:	HOME ADDRESS				
Telephone:	Home Address:				<u> </u>
E-mail: How would you like to receive your GOA Newsletter □Email □USPS PRIMARY WORK LOCATION Company Name: Street Address: City: State: Zip Code: Telephone: Fax: Preferred Mailing Address: □ Home Address □ Work Address PROFESSIONAL DATA School of Optometry: Month/Date/Year of Graduation: Year Originally Licensed in ANY State: (Dues are based off of original license date) GA Licenself: Date Licensed in GA: If you hold a license of optometry in another state(s) indicate: State(s): If you completed a residency, please indicate Month/Year Completed MODE OF PRACTICE Employed By: Self-Employed: □ Retired □ Optometrist □ Solo □ Group □ Retired □ Optometrist □ Solo □ Group □ Retired □ Optometrist □ Optometrist □ Optometry in Indicate State(s) □ Optometry in Retired □ Optometrist □ Optometrist □ Optometry in Independent Contractor □ Optometry in Indicate State(s) □ Optometry □ Independent Contractor □ Optometry □ Independent Contractor □ Optometry	City:	State:			Zip Code:
How would you like to receive your GOA Newsletter □Email □USPS PRIMARY WORK LOCATION Company Name: Street Address: City: State: Zip Code: Telephone: Fax: Preferred Mailing Address: □ Home Address □ Work Address PROFESSIONAL DATA School of Optometry: Month/Date/Year of Graduation: Year Originally Licensed in ANY State: [Dues are based off of original license date) GA Licensedf: Date Licensed in GA: If you hold a license of optometry in another state(s) indicate: State(s): If you completed a residency, please indicate Month/Year Completed MODE OF PRACTICE Employed By: □ Optometrist □ Optometri	Telephone:	Fax:		Cell:	
PRIMARY WORK LOCATION Company Name: Street Address: City: State: Telephone: Fax: Preferred Mailing Address: I Home Address Work Address Work Address PROFESSIONAL DATA School of Optometry: Month/Date/Year of Graduation: Year Originally Licensed in ANY State: (Dues are based off of original license date) Date Licensed in GA: If you hold a license of optometry in another state(s) indicate: State(s): If you completed a residency, please indicate Month/Year Completed MODE OF PRACTICE Employed By: Optometrist Optomet	E-mail:				· ••
Company Name: Street Address: City:	How would you like to receive your GOA News	sletter □Email □USF	PS .		
Street Address: City:	PRIMARY WORK LOCATION				
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Preferred Mailing Address:	Street Address:				
PROFESSIONAL DATA School of Optometry:	City:	State:			Zip Code:
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School of Optometry:					
Year Originally Licensed in ANY State:(Dues are based off of original license date) GA License#: Date Licensed in GA: If you hold a license of optometry in another state(s) indicate: State(s): If you completed a residency, please indicate Month/Year Completed MODE OF PRACTICE Employed By: Self-Employed: Not Currently Active in Practicing Optometry: Optometrist Solo Group Retired Unemployed: Unemployed HMO GOPICAL Chain Franchise or Lessee GOTHER: Hospital/Clinic/Other Multidisciplinary Independent Contractor Hours Worked: Optical Chain Gother: Independent Contractor Inde	PROFESSIONAL DATA			<u> </u>	
Date Licensed in GA: If you hold a license of optometry in another state(s) indicate: State(s): If you completed a residency, please indicate Month/Year Completed MODE OF PRACTICE Employed By:	School of Optometry:	·	Month/	Date/Year of	Graduation:
MODE OF PRACTICE Employed By: Optometrist Ophthalmologist Hospital/Clinic/Other Multidisciplinary Optical Chain Armed Forces/VA/USPHS/Government MODE OF PRACTICE Self-Employed: Self-Employed: Optometry: Self-Employed: Optometry: Self-Employed: Optometry: Self-Employed: Optometry: Optometr	Year Originally Licensed in ANY State:	(Dues are based off of	foriginal license date) G	A License#:_	
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□ Optometrist □ Solo □ Group □ Retired □ Ophthalmologist # of ODs working here: □ Unemployed □ HMO □ Optical chain Franchise or Lessee □ Other: □ Hours Worked: □ Hospital/Clinic/Other Multidisciplinary □ Independent Contractor □ I work 16 hours or less per week □ Optical Chain □ Other: □ I work 16 hours or less per week □ Armed Forces/VA/USPHS/Government Do ophthalmologists practice at (total at all work locations)	MODE OF PRACTICE				
	□ Optometrist □ Ophthalmologist □ HMO □ Hospital/Clinic/Other Multidisciplinary □ Optical Chain □ Armed Forces/VA/USPHS/Government	□ Solo □ Group # of ODs working here: □ Optical chain Franchi □ Independent Contrac □ Other: □ Do ophthalmologists pr	ise or Lessee tor	□ Retired □ Unempl □ Other: _ Hours Wo □ I work 1 (total at al	oyed rked: 6 hours or less per week Il work locations)

In order for this membership apparent of \$	using the cre	dit/debit card lis	sted below. I	understand thi	s amount will o	complete the membership
orocess and will cover the first qu		·		_	ie total dues ob	nigation and authorize
□ Quarterly amount of \$	An	nual amount o	f \$			•
to be automatically processe Association and the America understand that I will have 30 Please use the 2016 dues sca	n Optometric <i>A</i>) days to upda	Association. I te my automa	f for any re itic payment	ason my card information o	d does not pa r will use and	rocess automatically,
Major Credit Card		EX	(P.DATE		CVC Securi	ty #
Nama Associated With Card						
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Billing Address For Card					· · · · · · · · · · · · · · · · · · ·	
APPLICANT SIGNATURE			DATE			
TO BE COMPLETED BY GOA O	FFICE					•
The applicant will be a member of	the	Dist	frict			
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The applicant above is □ Appr	oved Der	nied for member	rship			
Signature				Date:		
GOA S	ecretary				.*	
	, -	1st Calendar			,	•
		Year Active	Second	Third	Fourth	Fifth
•	New Licensee	<u>Practice</u>	<u>Year</u>	<u>Year</u>	<u>Year</u>	<u>Year</u>
ORIGINAL LICENSED	2016	2015	2014	2013	2012	2011 & Before
GOA:						
Month	\$0.00	\$7.03	\$14.06	\$35.16	\$52.74	\$70.31
Quarter	\$0.00	\$21.10	\$42.19	\$105.47	\$158.21	\$210.94
Year	\$0.00	\$84.38	\$168.75	\$421.88	\$632.82	\$843.76
AOA:		_				Απ
Month	\$0.00	\$7.48	\$14.97	\$37.42	\$56.13	\$74.83
Quarter	\$0.00	\$22.45	\$44.90	\$112.25	\$168.38	\$224.50
Year	\$0.00	\$89.80	\$179.60	\$449.00	\$673.50	\$898.00
GOA/AOA						
Month	\$0.00	\$14.52	\$29.03	\$72.57	\$108.86	\$145.15

\$87.09

\$348.35

\$217.72

\$870.88

\$43.55

\$174.18

\$0.00

\$0.00

Quarter

Year

\$326.58

\$1,306.32

\$435.44

\$1,741.76