Palm Beach County Ophthalmology Society, Inc.

Membership Application

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 $145.00 per year.

Please Mail this completed application and your check for Membership Dues of $145.00 (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