

# Application for Membership in the Minnesota Optometric Association



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

## Primary Practice Address

Business Name: \_\_\_\_\_  
Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

## Home Address

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

Where should the MOA send correspondence and contact you?  Primary Practice  Home

## Licensure and Education

MN License Number: \_\_\_\_\_ Date of Licensure: \_\_\_\_\_ TPA Certified:  Yes  No  
Other state(s) in which you are licensed and date of licensure: \_\_\_\_\_  
College of Optometry: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_  
Undergraduate School: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_ Degree: \_\_\_\_\_

## Specialties / Areas of Clinical Interest

- Contact Lenses
- Low Vision
- Pediatrics
- Refractive Services
- Vision Training and Developmental Optometry
- Geriatric Vision
- Multidisciplinary Practice
- Primary Care Optometry
- Sports Vision

## Additional Capabilities

- Foreign Language \_\_\_\_\_
- ASL (American Sign Language)
- Hospital Privileges at \_\_\_\_\_
- Mobile equipment to visit nursing homes or homebound patients

Have you ever been accepted for membership in the American Optometric Association through any other state? (Please list states and date of membership) \_\_\_\_\_

## Previous practice information

City: \_\_\_\_\_ State: \_\_\_\_\_ Dates: \_\_\_\_\_

Briefly describe why you seek membership in the Minnesota Optometric Association and the American Optometric Association: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Please select your areas of interest

- Serving on an MOA Committee  
Areas of Interest: \_\_\_\_\_
- Serving in the Leadership of the MOA
- I prefer to receive the MOA Newsletter, meeting preliminary and final programs electronically with e-mail notification when a publication is available.  
E-mail: \_\_\_\_\_
- Serving as volunteer provider in the Minnesota Vision Project/Vision USA
- Other: \_\_\_\_\_
- Active Legislative Involvement

I have read and subscribe to the "Code of Ethics" and "Standard of Practice" of the Minnesota Optometric Association and Regulations of the Minnesota State Board of Optometry.

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