

Pan-American Association of Ophthalmology

Asociación Panamericana de Oftalmología

Associação Pan-Americana de Oftalmologia



1301 South Bowen Road, Ste. 365, Arlington, Texas USA 76013-2286
 tel: (817) 275-7553 fax: (817) 275-3961 email: membership@pao.org http://www.pao.org

MEMBERSHIP APPLICATION

<input type="checkbox"/> Active Member (\$150) -living in North, Central & South America	<input type="checkbox"/> Member-in-Training (\$50) -in fulltime training program	<input type="checkbox"/> Corresponding Member (\$100) -living outside western hemisphere
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APPLICANT INFORMATION

(Please print clearly)

Last Name(s) _____ Suffix(es)(Sr, Jr, etc) _____ Degrees (MD, PhD) _____

First Name(s) _____ Middle Name(s) _____

Mailing Address _____

Mailing Address (continued) _____

City _____ State _____ ZIP _____ Country _____

Telephone _____ FAX _____

Email: _____

Name as you wish it to appear on your membership certificate _____

Languages: English Spanish Portuguese

Date of Birth: _____ / _____ / _____
month day year

TRAINING

Ophthalmology Residency Program _____ year completed _____

Fellowship Program _____ year completed _____

Subspecialty Interest _____

CERTIFICATION

Please list the countries in which you are licensed to practice medicine. Attach a copy of your membership certificate from the appropriate affiliated national society.

I understand and agree that my continued status as an Active Member (Miembro Titular) will be subject to all of the terms and conditions of the ByLaws of the PAAO, and that the Board of Directors of the PAAO may revoke my membership if this application contains or is supported by information that omits or contains a substantial misstatement of any fact required or permitted by this application or the related instructions to be included on or submitted with or in support of this application.

Applicant's Signature _____ Date _____

Application Endorsement

Application MUST be endorsed by one (1) Active Member (Miembro Titular) or Life Member.

I, _____
(please print name of endorser in full)

certify that I am an Active Member (Miembro Titular) or Life Member of the PAAO; that I know the applicant

_____;
(please print name of applicant in full)

that I am familiar with the applicant's professional competence and conduct; that the applicant has attained a high level of professional competence and conforms to the ethical standards of the PAAO; and that upon request I shall provide all necessary information to verify the truth and accuracy of this certification.

Endorser's Signature _____ date _____

METHOD OF PAYMENT

Payable to PAAO (include payment with application)

Check One: Cash Check # _____

Electronic Transfer (PAAO Account #5046776, Summit Bank, PO Box 2665, Ft. Worth, TX 76113, Routing/ABA#111914027)

ALL WIRES MUST CONTAIN APPLICANT NAME

Int'l Visa Int'l MasterCard American Express

If paying with a credit card, please complete the following information:

 Credit Card Number (required)

 Name as it appears on the Credit Card

 Cardholder's Signature Exp. Date (required)

Please note that a portion of your dues payment is considered a donation to the Pan-American Ophthalmological Foundation

Do not write in this space; for accounting purposes only.

Payment Received: _____ ID #: _____

Date: _____ Status: _____

By: _____ Source: web

Amount: _____ Payment Entered: _____

Payment type: _____ Date: _____

Dues Year: _____ By: _____