

Combined Membership Application

Thank you for your interest in the Wisconsin Academy of Ophthalmology. We certainly appreciate your participation in the organization and trust you will find it to be a beneficial experience. You may use this application for both the "practice" membership category, as well as the "individual" membership. Please follow these instructions for completing the application. Return it along with the appropriate dues payment to:

Wisconsin Academy of Ophthalmology
10 W. Phillip Rd., Suite 120
Vernon Hills, IL 60061-1730

If you are paying your dues by credit card, you may fax your application to us at 847/680-1682.

Questions? Call us at (800) 780-4312 or send email to: RichardPaul@dls.net

INSTRUCTIONS

Please type or print!

① Step 1 – Membership Category (page 2)

- ✓ Determine the membership category that applies to you. The "practice" category provides membership to *all* ophthalmologists in your practice. It also includes certain additional benefits for the practice and your non-physician employees which are not available to individual members. The "individual" membership applies only to the ophthalmologist joining, and member benefits are restricted to that person.
- ✓ Check the appropriate box to indicate the category of membership applied for and determine your dues. Practice members please note: If you have any ophthalmologists in your practice who are in their first, second or third year of practice, or semi-retired contact the WAO office so we can apply the "new ophthalmologist" discount to your practice dues.
- ✓ Indicate your method of payment. If paying by check, make it out to "Wisconsin Academy of Ophthalmology." If paying by Visa or MasterCard, enter your card number and expiration date and be sure to sign where indicated.

② Step 2 – Practice information (page 3)

- ✓ Whether or not you are applying for the "practice" or "individual" category, please provide the information requested in this section. Data about the number of employees and number of ophthalmologists in your practice will be kept confidential. We use that only for our own planning purposes.
- ✓ Be sure to include the address and phone number for each office location. This information will enable us to refer patients to you. Use an additional sheet of paper, if necessary.

③ Step 3 – Individual information (page 4)

- ✓ Please provide the information requested for each doctor in your practice applying for membership. If applying for the "practice" category, this would include all of your ophthalmologists. If an individual membership, then supply information only for that doctor. Copy this page as many times as necessary (one page per doctor).

For Office Use Only

Date received:

Dues deposited:

✓ number:

Date considered by BOD:

Board action: Approved Deferred Not approved

Category of Membership and Dues Calculation

WAO offers a number of membership categories and options to meet your needs. Following is a short summary of your choices, along with the dues amounts for each category. Doctors have the choice of either an **individual** membership or a **practice** membership. WAO membership is based on the "fiscal" year (July 1 through June 30). Membership privileges are not transferrable. Several dues payment methods are offered, including checks, credit cards, semi-annual (paid in two installments) and monthly (charged to a credit card).

PRACTICE MEMBERSHIP CATEGORIES

*For entire practices. Provides full membership for all ophthalmologists in the practice, as well as member benefits for non-physician employees and the practice itself. Doctors in a member practice do not also need an individual membership. Dues are based on the number of ophthalmologists in the practice. **Discounts available if any practice physicians qualify for categories A1, A2, A3 (new in practice), as well as for part-time or semi-retired doctors.***

P1 – Practice I	Solo doctor practice	\$525
P2 – Practice II	2-doctor practice	\$1,025
P3 – Practice III	3-doctor practice	\$1,520
P4 – Practice IV	4-doctor practice	\$2,000
P5 – Practice V	5-doctor practice	\$2,490
P6 – Practice VI	6 - 8 doctors in the practice	\$2,950
P7 – Practice VII	9 and more doctors in the practice	\$4,290

INDIVIDUAL MEMBERSHIP CATEGORIES

Personal membership for the doctor. Ophthalmologists with an individual membership may take advantage of most member benefits personally, but these services are not transferrable to the entire practice or non-physician employees. Due to their nature, some member benefits are available only to practices and, thus, require a practice membership.

AF – Active	Full active member	\$525.00
A1 – Active 1	New ophthalmologist in the <i>first</i> year of practice (out of training)	\$131.25
A2 – Active 2	New ophthalmologist in the <i>second</i> year of practice	\$262.50
A3 – Active 3	New ophthalmologist in the <i>third</i> year of practice	\$393.75
Rx – Resident/Fellow	Enrolled in an accredited residency or fellowship	Complimentary
RT – Retired	Completely retired from practice	\$10.00
## – Semi-retired	Semi-retired (number indicates % time practicing)	Pro-rated
OS – Out-of-state	Primary practice is outside Wisconsin <u>and</u> is a member of home state ophthalmology society	\$131.25

Dues Payment

Enter the amount of your dues payment, based on membership category selected above \$_____

Form of payment: Check* Visa MasterCard

Credit Card #																				Exp. Date			/		
																		Security Code (on back of card)							

Name on card: _____

Signature _____

PRACTICE INFORMATION

Full practice name	
Primary office street address	
City/State/Zip	
Other mailing address (i.e., P.O. Box) <i>Include city/state/zip</i>	
County (where primary office is located)	
Office Manager/Practice Administrator	
Office Phone (include area code)	
Office Fax (include area code)	
E-mail address	
Send mail to:	<input type="checkbox"/> Office address <input type="checkbox"/> Home address
Number of ophthalmologists in practice	
Type of Practice?	<input type="checkbox"/> Academic <input type="checkbox"/> Large Group <input type="checkbox"/> Small Group <input type="checkbox"/> Solo <input type="checkbox"/> Military/VA <input type="checkbox"/> Multi-specialty clinic
Number of employees in your practice	
Does your practice have an optical dispensary?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p align="center">Satellite Offices</p> <p>So that our referral service can be effective, please provide us with <u>all</u> of your office locations. This information will enable us to provide names of our members to prospective patients. List the street address, city, state, zip code and phone number.</p> <p>Feel free to use an additional sheet of paper if necessary.</p>	Street Address
	City/State/Zip
	Phone #
	Street Address
City/State/Zip	
Phone #	
Street Address	
City/State/Zip	
Phone #	

INDIVIDUAL DOCTOR LISTINGS

Copy this page and complete for each ophthalmologist

<p align="center">Applicant's name Degree(s) - check all that apply AAO ID # _____</p>	<p align="center">_____</p> <p align="center"><input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> PhD <input type="checkbox"/> Other _____</p>														
<p align="center">Home address (will not be published!)</p>	<p>_____</p>														
<p align="center">Home address City/State/Zip</p>	<p>_____</p>														
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<p align="center">Personal E-mail address</p>	<p>_____</p>														
<p align="center">Do you speak a foreign language?</p> <p>If yes, please list and whether you are fluent</p>	<p align="center"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p align="right"><input type="checkbox"/> Fluent</p> <p align="right"><input type="checkbox"/> Fluent</p> <p align="right"><input type="checkbox"/> Fluent</p>														
<p align="center">Wisconsin medical license number</p>	<p>_____</p>														
<p align="center">Board certification(s) & date(s)</p>	<p>_____</p>														
<p align="center">Medical school & Year graduated</p>	<p>_____</p>														
<p align="center">Ophthalmology residency program(s) Location(s) & Dates</p>	<p>_____</p>														
<p align="center">Fellowship(s) completed Subspecialty, Location(s) & Date(s)</p>	<p>_____</p>														
<p align="center">Indicate your <i>primary</i> practice focus or subspecialty. Also, please note whether you perform refractive surgery. This information is an essential part of our patient referral service.</p>	<p><input type="checkbox"/> I primarily practice <u>general ophthalmology</u></p> <p>Subspecialties:</p> <table border="0"> <tr> <td><input type="checkbox"/> Contact lenses</td> <td><input type="checkbox"/> Cornea/external diseases</td> </tr> <tr> <td><input type="checkbox"/> Glaucoma</td> <td><input type="checkbox"/> Neuro-ophthalmology</td> </tr> <tr> <td><input type="checkbox"/> Retina/vitreous</td> <td><input type="checkbox"/> Uveitis</td> </tr> <tr> <td><input type="checkbox"/> Pediatric care</td> <td><input type="checkbox"/> Ophthalmic pathology</td> </tr> <tr> <td><input type="checkbox"/> Low vision</td> <td><input type="checkbox"/> Plastic & reconstructive</td> </tr> <tr> <td><input type="checkbox"/> AIDS/HIV</td> <td><input type="checkbox"/> Oncology</td> </tr> </table> <p><i>Do you perform refractive surgery?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Contact lenses	<input type="checkbox"/> Cornea/external diseases	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Neuro-ophthalmology	<input type="checkbox"/> Retina/vitreous	<input type="checkbox"/> Uveitis	<input type="checkbox"/> Pediatric care	<input type="checkbox"/> Ophthalmic pathology	<input type="checkbox"/> Low vision	<input type="checkbox"/> Plastic & reconstructive	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Oncology		
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