CONTACT & DEMOGRAPHIC INFORMATION

If business name and address are not provided, the member will not appear in the Doctor Locator website.

CONTACT PREFERENCE: ☐ **PERMANENT** ☐ **CURRENT**

Permanent Address:	Current Address:
______________________	______________________
______________________	______________________
City: ______ State: ______ Zip: ______	City: ______ State: ______ Zip: ______
Phone: ( ) ______	Phone: ( ) ______
Cell: ( ) ______	Cell: ( ) ______
Email: ______	Email: ______

Date of Birth: ______ (mm / dd / yyyy)

Gender: ☐ Male ☐ Female ☐ Choose Not to Disclose

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Unknown ☐ Choose Not to Disclose

Name of Spouse: ______________________

Political Affiliation: ☐ Democrat ☐ Republican ☐ Independent ☐ Libertarian ☐ Green ☐ Unknown ☐ Choose Not to Disclose

Ethnicity / Race: Hispanic / Latino origin? ☐ Yes ☐ No and / or

☐ White ☐ Black / African-American ☐ Asian ☐ Native American ☐ Alaska Native / Pacific Islander

☐ Other ______________________

Military Service:

BRANCH:

☐ Army ☐ Marine Corps ☐ Navy

☐ Air Force ☐ Coast Guard ☐ National Guard

STATUS:

☐ Active ☐ Inactive ☐ Deactivated

☐ Reserves ☐ Retired

OPTOMETRIC INFORMATION

Optometry School(s) Attended: ______________________ Year of Graduation: ____________

Licenses Obtained:

State(s): ______________________ Year(s): __________ NPI Number: ______________

______________________ __________

VERIFICATION OF POST GRADUATE STATUS

THIS INFORMATION IS REQUIRED TO PROCESS THIS APPLICATION

It is the affiliate's responsibility to obtain verification from the school or college of the member's post graduate status. The application cannot be processed with missing or incomplete verification information.

SCHOOL AFFILIATION:

____

RESIDENCY SITE NAME:

____

RESIDENCY CITY/STATE:

____

RESIDENCY BEGIN DATE (MONTH/YEAR):

____

RESIDENCY END DATE (MONTH/YEAR):

____

CURRENT RESIDENCY, INTERNSHIP OR GRADUATE PROGRAM:

- ☐ Brain Injury
- ☐ Community Health
- ☐ Cornea & Contact
- ☐ Family Practice
- ☐ Geriatric Optometry
- ☐ Hospital Based Care
- ☐ Low Vision Rehab
- ☐ Ocular Disease
- ☐ Pediatric Optometry
- ☐ Primary Eye Care
- ☐ Refractive Surgery
- ☐ Vision Therapy & Rehab

AOA OFFICE USE ONLY

AOA ID Number: ____________ **Processed By:** ____________ **Date:** ____________
mm / dd / yyyy

Comments: ____

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