UTAH OPHTHALMOLOGY SOCIETY

Eye M.D.s of Utah

Application for Membership

Please type or print legibly

Biographical Data

Last Name: ________________________ First: ________________________ Middle: ____________

Name of Practice: ____

Primary Office address: ________________________ City: ________________ Zip Code: __________

Name of Physicians in your practice: ____

Home address: ________________________ City: ________________ Zip Code: __________

Office Phone: ________________ Home phone: ________________ Birth date: __________

Email Address: ____

Preferred Mailing Address: Office _______ Home: _______

Male ________ Single ________ Native Citizen ________
Female ________ Married ________ Naturalized Citizen _____

Spouse's name: ________________________ Spouse's Occupation: ________________

Education

Undergraduate College & Year of graduation: ________________________________

Medical School: ________________ Degree: __________ Year graduated: __________

Internship: ________________________________ Year completed: __________

Residency (Type & Place): ______________________ Year completed: __________

Graduate Training: ________________________________ Year completed: __________

Licensing/Certifications/Affiliations

Utah License number: ____________________ Date of license: ____________________

Board certification (board name & date): ____________________________________

American Academy of Ophthalmology status: Member ___ Fellow ___ Non-member ___

American Medical Association: Member ___ Non-member ___
Utah Medical Association: Member ___ Non-member ___

Other Society memberships: ____

Hospital Affiliations (active staff): ____

Recommended by (2 physician signatures required):

________________________________, MD ________________________________
Name printed Signature

________________________________, MD ________________________________
Name Printed Signature

I certify that I meet the above listed criteria established for the category of membership for which I am applying and authorize the UOS to verify the accuracy of information provided. Furthermore, I agree to abide by the UOS Bylaws.

____
Signature of applicant Date of application

For UOS Board Approval: Date of approval ________________________________

Utah Ophthalmology Society 3/9/10

Please fax, mail or email to:
310 East 4500 South, Ste. 500, Salt Lake City, Utah 84107-4250 (801) 747-3500 FAX (801) 747-0851 uos@utahmed.org