SD Optometric and American Optometric Membership Application

NAME:

________________________ ________ __________________________ ____________
First Middle Initial Last Suffix (Jr., Sr., etc.)

_____________________________________ ________________________________
Designations (O.D., Ph.D., etc.) Maiden Name (if applicable)

Check appropriate reason for application:
_____ New Member ______Reinstated member _____ Transfered from: ___________________________

SD Board of Optometry License #______________ (Required) Spouse__________________________________ (First Name & Last Name)

CONTACT INFORMATION:

E-Mail Address:____

Home Address:

____
____
____
____

Cell Phone: ___________________________
Telephone:____________________________
FAX: ________________________________

Business Address:

____
____
____
____

Business Name:__________________________________
Telephone: _____________________________________
FAX:____

Indicate address to which mail should be sent _____ Business address _____Home address
May we contact you by email _____ Yes _____ No
Preferred method of contact: _____ Email _____ Mail

DEMOGRAPHIC INFORMATION:

_____ Male _____ Female Date of Birth: ___________________________**(required)**
Social Security Number **(optional)**____
Name of Optometry school attended: ____
Year of graduation: ______________________ Year original license obtained: ___________
List other states licensed in: ____
Indicate practice specialty: ____
Indicate area(s) of interest: _____Contact Lens _____Low Vision _____ Sports Vision
Other____
Comments:____
____

SIGNATURE:___________________________ **DATE:**___________________

Please provide a wallet or digital photo for the SDOS Directory

Return application to: **Deb Mortenson**
Executive Director
South Dakota Optometric Society
PO Box 1173
Pierre, SD 57501

Please call Deb at the SDOS office 605-224-8199 if you have any questions or email sdeyes3@pie.midco.net