PAAO Membership Application Form

☐ Active/Miembro Titular ($150)
☐ Member-in-Training ($50) – In a full-time training program
☐ Corresponding Member ($100) – Living and practicing outside the Western Hemisphere

PAAO Active Membership

An applicant for Active Membership (Miembro Titular membership) in the PAAO shall be a physician who holds a degree of Doctor of Medicine, Doctor of Osteopathy (or an equivalent medical degree as determined by the Board of Directors), who holds a valid and unrestricted license to practice medicine in the country in which the practice of medicine is regularly conducted, who has completed formal training in ophthalmology (or its equivalent, as determined by the Board of Directors), and who is a member in good standing of the national society affiliated with the Association in the country in which the practice of medicine is regularly conducted. If the candidate has a practice in more than one country, he or she must be a member in good standing of the national society affiliated with the Association in each country in which the practice of medicine is conducted.

MEMBERSHIP BENEFITS

- Reduced registration fees at PAAO congresses and regional meetings.
- Through the Visiting Professors Program selected members travel to National Congresses with their round-trip coach airfare paid by the PAOF.
- The Fellowships Committee provides a listing of fellowships, observerships and travel awards.
- The Research Committee reviews research grant applications. Funding provided by the PAOF.
- The PAAO's quarterly newsletter *Vision Pan-America.*
- A membership certificate.
- A membership card valid for the calendar year and issued upon payment of membership dues.

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: ______ / ______ / ______ (mm/dd/yyyy)

TRAINING

Residency Program year completed

Fellowship Program year completed

Subspecialty Interest(s)

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 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 Funds Transfer
Account #2732814989; Account name: Pan-American Association of Ophthalmology; Bank name: JPMorgan Chase Bank; Bank Address: 1301 S Bowen, Arlington TX 76013; Routing/ABA 111000614; SWIFT code CHASUS33) INCLUDE NAME ON ALL TRANSFERS

☐ Int'l Visa ☐ Int'l MasterCard ☐ American Express

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

Credit Card Number (required)

______/ ______ ______________
Expiration Date (mm/yyyy) Security code

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 (PAOF).

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: ______________

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