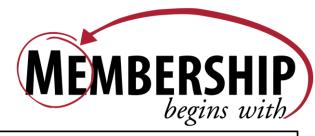
CALIFORNIA OPTOMETRIC ASSOCIATION BECOME A MEMBER TODAY!



| I was referred to membership by: | Vision West, COA's Preferred Eyecare Business Group, will award FREE COA DUES to the three members who recruit VISION | | | | | |
|---|---|---|--|--|--|--|
| COA Member Name and License# (please pr | rint) | the most new members in 2015 | | | | |
| Date of Application: | NEW | REINSTATE | | | | |
| Name: | // | Designation (OD, FAAO, | | | | |
| Local Society (if known): | // | | | | | |
| IMARY WORK LOCATION | / | | | | | |
| Street Address: | □ Preferre | ed <u>Mailing</u> Address 🗅 Preferred <u>Billing</u> Ad | | | | |
| City: | State: | Zip Code: | | | | |
| Telephone: Fax:_ | | E-mail: | | | | |
| Company Name (optional): | Practice/Office Web Site: | | | | | |
| OME ADDRESS | | | | | | |
| | ☐ Preferre | ed <u>Mailing</u> Address 🚨 Preferred <u>Billing</u> Ad | | | | |
| Home Address: | | | | | | |
| City: | State: | Zip Code: | | | | |
| Telephone:Fax: | | E-mail: | | | | |
| | | | | | | |
| ODE OF PRACTICE | | | | | | |
| | <u>yed By:</u> | lf other than regular full-tin | | | | |
| □ Solo □ Group □ Opto # of ODs working here: □ Opht | ometrist thalmologist | ☐ I work 16 hours or less per w | | | | |
| | cal Chain | total at all work locations. | | | | |
| | ed Forces/VA/USPHS/Government | I work as a full-time Faculty Member at: | | | | |
| | ol/University | | | | | |
| ☐ Indu | stry er (specify) | Not Currently Active in Practicing | | | | |
| Do ophthalmologists practice at this location? | (5p00) | _ <u>Optometry</u> : ☐ Retired* ☐ Unemployed | | | | |
| ☐ Yes ☐ No | | Other (specify): | | | | |
| *A mambar must be a dues naving member for any sale | andar year before they can apply f | or retired membership. New retired membe | | | | |
| will be billed at the discounted partial practice rate. | muai yeui bejore they can appty j | | | | | |
| will be billed at the discounted partial practice rate. | muur yeur bejore they cuiruppty j | | | | | |
| will be billed at the discounted partial practice rate. | muur yeur bejore they cuiruppty j | | | | | |
| will be billed at the discounted partial practice rate. | | Type: ☐ Non DPA ☐ DPA ☐ TPA ☐ 1 | | | | |
| will be billed at the discounted partial practice rate. | License - | | | | | |
| will be billed at the discounted partial practice rate. ROFESSIONAL DATA CA License#:Date Licensed: | License - indicate: State(s): | License Year(s): | | | | |
| CA License#: Date Licensed: If you hold a license of optometry in another state(s) | License indicate: State(s): , please indicate State: | License Year(s): | | | | |

| DEMOGRAPHICS Optional | | | | | | | |
|--|---|---|------------------------------------|----------------------------|---------------------------------|--|--|
| • | France / d d /] | Gender: | □ wata | ☐ Female | | | |
| Date of Birth: Marital Status: | | ☐ Widowed | ☐ Mate | ☐ Divorced | | | |
| Name of Spouse (if applicable): | | | | | | | |
| Ethnicity: American-Indian Other: | ☐ African-American | ☐ Asian/Pacific Islander ☐ Caucasian | | | ☐ Hispanic | | |
| MEMBER PREFERENCES | | | | | | | |
| Find An Eye Doc is a free lis public to use in searching for YES! Please include my | an optometrist in their o | ırea. | | line locator servi | ice for the general | | |
| News Delivery: COA produces coveted Government Affairs Wed | • | • | , , | | tometry, and the Yes No | | |
| Online Membership Director I DO NOT WISH my contact | | | | r for COA members | only. | | |
| PAYMENT INFORMATION | | | | | | | |
| Yes, I authorize COA to character Wisa MasterCard | rge my credit card for m al dues. (Charges will be rge my credit card for m | y COA membershi e in Jan, Apr, July y COA membershi n the 10 th of each | p dues in and Sept p dues in | quarterly insta t) | • | | |
| ☐ Business ☐ Personal Credit Card | # | CVC Expiration Date: | | | | | |
| Name on Card: | | Business Name (if applicable): | | | | | |
| Billing Street Address: | | City, State, Zip Code: | | | | | |
| Signature: | | Date: | | | | | |
| Yes, I authorize COA to inite equal to one twelfth of my transactions must comply we of each month. | ate debit entries to my total annual COA membe | ership dues. I ackr | nowledge | that the origina | tion of ACH | | |
| Name(s) on Checking Account: | | | | | | | |
| Business Name on Checking Account | (if applicable): | | | | | | |
| Routing Number: Account Number: | | | | | <u></u> | | |
| Signature: | ignature: Date: | | | | | | |
| I hereby apply for membersh the (local) If accepted, I will abide by Signature: | their bylaws, Code of Et | hics, and agree to | pay all du | Optome les and assessme | etric Society. nts promptly. | | |