Submit by Email

CALIFORNIA OPTOMETRIC ASSOCIATION

# Low Vision Rehabilitation Section

*Membership Application*

Date: _____

## MEMBER INFORMATION

Name: _____ License #: _____

E-mail*: _____

*(please provide an e-mail address that will reach you directly since communications will primarily be conducted this way)

## SECTION MEMBERSHIP

☐ I hereby apply for membership in the Low Vision Section of the California Optometric Association. If accepted, I will abide by its bylaws, support its objectives and pay the established annual dues. I understand that my membership is also contingent on remaining a member in good standing with the California Optometric Association.

Membership Dues: $50 provides membership in the Low Vision Section for one calendar year, January through December. It is not refundable or transferable.

## PAYMENT METHOD

☐ Check (please enclose and make payable to California Optometric Association)
☐ Credit Card: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

Card Number: _____ Expiration Date: _____

Name on Card: _____

Billing Street Address: _____

City: _____ State: _____ Zip Code: _____

Authorized Signature: _____

**LOW VISION SECTION**
CALIFORNIA OPTOMETRIC ASSOCIATION
2415 K Street Sacramento CA 95816 • Toll Free (800) 877-5738 / (916) 441-3990 • Fax (916) 448-1423