CALIFORNIA OPTOMETRIC ASSOCIATION
BECOME A MEMBER TODAY!

MEMBERSHIP *begins with*

I was referred to membership by:

_____

COA Member Name and License# (please print)

*Vision West, COA's Preferred Eyecare Business Group, will award **FREE COA DUES** to the three members who recruit the most new members in 2015*

VISION WEST® COA Preferred Eyecare Business Group

Date of Application: _____

☐ **NEW** ☐ **REINSTATE** ☐ **TRANSFER**

Name: _____

Designation (OD, FAAO, etc.)

Local Society (if known): _____

PRIMARY WORK LOCATION

❑ ***Preferred Mailing Address*** ❑ ***Preferred Billing Address***

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____ E-mail: _____

Company Name (optional): _____ Practice/Office Web Site: _____

HOME ADDRESS

❑ ***Preferred Mailing Address*** ❑ ***Preferred Billing Address***

Home Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____ E-mail: _____

MODE OF PRACTICE

Self-Employed:

❑ Solo ❑ Group
# of ODs working here: _____
❑ Optical chain Franchise or Lessee
❑ Independent Contractor
❑ Other Self-Employed (specify):

_____

Do ophthalmologists practice at this location?
❑ Yes ❑ No

Employed By:

❑ Optometrist
❑ Ophthalmologist
❑ Optical Chain
❑ Armed Forces/VA/USPHS/Government
❑ School/University
❑ Industry
❑ Other (specify) _____

If other than regular full-time

❑ **I work 16 hours or less per week** total at all work locations.

❑ **I work as a full-time Faculty Member at:** _____

Not Currently Active in Practicing Optometry:

❑ Retired* ❑ Unemployed
❑ Other (specify): _____

**A member must be a dues paying member for one calendar year before they can apply for retired membership. New retired members will be billed at the discounted partial practice rate.*

PROFESSIONAL DATA

CA License#: _____ **Date Licensed:** _____ **License Type:** ❑ Non DPA ❑ DPA ❑ TPA ❑ TLG

If you hold a license of optometry in another state(s) indicate: State(s): _____ License Year(s): _____

If you are transferring from another state association, please indicate State: _____

School of Optometry: _____ **Year of Graduation:** _____

Did you attend a Post-Graduate/Residency Program? ❑ No ❑ Yes Year Completed: _____

Post-Graduate/Residency Program Location: _____

DEMOGRAPHICS

Optional

Date of Birth:_____[mm/dd/yy] **Gender:** ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Name of Spouse (if applicable):_____ If your spouse is an OPTOMETRIST, list his/her license #:_____

Ethnicity: ❑ American-Indian ❑ African-American ❑ Asian/Pacific Islander ❑ Caucasian ❑ Hispanic
❑ Other:_____

MEMBER PREFERENCES

Find An Eye Doc *is a free listing offered to COA member optometrists. It is an online locator service for the general public to use in searching for an optometrist in their area.*
❑ ***YES! Please include my practice/place of employment in this listing.***

News Delivery: *COA produces a monthly bulletin, COA Member News, a bi-monthly magazine, California Optometry, and the coveted Government Affairs Weekly notice. Would you like to receive these informative emails from COA?* ❑ Yes ❑ No

Online Membership Directory: *Basic contact information will be included in a directory for COA members only.*
❑ I DO NOT WISH my contact information to be available in the online directory

PAYMENT INFORMATION

CREDIT CARD OPTIONS

❑ ***Yes, I authorize COA to charge my credit card for my full annual COA membership dues.***
❑ ***Yes, I authorize COA to charge my credit card for my COA membership dues in quarterly installments equal to one fourth of my total annual dues. (Charges will be in Jan, Apr, July and Sept)***
❑ ***Yes, I authorize COA to charge my credit card for my COA membership dues in monthly installments equal to one twelfth of my total annual dues. (Charges will be on the 10th of each month)***

❑ Visa ❑ MasterCard ❑ American Express ❑ Discover

❑ Business ❑ Personal Credit Card # _____ CVC_____ Expiration Date: _____

Name on Card: _____ Business Name (if applicable): _____

Billing Street Address: _____ City, State, Zip Code: _____

Signature: _____ Date: _____

ACH OPTION

❑ ***Yes, I authorize COA to initiate debit entries to my Checking Account indicated below for monthly installments equal to one twelfth of my total annual COA membership dues. I acknowledge that the origination of ACH transactions must comply with the provisions of U.S. law, and my account will be debited within the first week of each month.***

Name(s) on Checking Account: _____

Business Name on Checking Account (if applicable): _____

Routing Number: Account Number: _____

Signature: _____ Date: _____

I hereby apply for membership in the California Optometric Association, the American Optometric Association and the (local) _____ Optometric Society.
If accepted, I will abide by their bylaws, Code of Ethics, and agree to pay all dues and assessments promptly.

Signature:_____ Date:_____

California Optometric Association
2415 K Street, Sacramento, CA 95816
916) 441-3990 | Toll Free (800) 877-5738 | Fax (916) 469-2896
www.coavision.org | membership@coavision.org