



Educator Status Change

This application is used to report a new or reinstated optometric educator member, a current member requesting a change in status back to optometric educator.

NAME AND CONTACT INFO

First M. I. Last Suffix

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

Home Address: _____

Practice Name/Business Address: _____

Phone: _____

FAX: _____

Cell: _____

E-Mail _____

Address: _____

Phone: _____

FAX: _____

Indicate address to which mail should be sent: Home address Business address

DEMOGRAPHIC INFORMATION

Male Female Date of Birth: _____

Social Security number (optional): _____

Name optometry school: _____

Year of graduation: _____ Original license Year: _____

List other states licensed in: _____

REQUIRED INFORMATION

*Name and address of school or college where currently employed: _____

*Is applicant's status as an educator considered full-time by the school or college? Yes No
If no, in accordance with Article I. Membership, Section 1.E. of the Bylaws, the educator is not eligible for optometric educator membership. Contact AOA Dues Accounting for further clarification, if needed.

*Position held: _____

*Description of responsibilities: _____

*Does applicant work in the industrial, clinical or private practice of optometry more than 16 hours per week? Yes No
If yes, in accordance with Article I. Membership, Section 1.E. of the Bylaws, the educator is not eligible for optometric educator membership.

* Application cannot be processed or approved without this information.