



# New Hampshire Optometric Association

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Prepared By \_\_\_\_\_

Date \_\_\_\_\_

## 2017 APPLICATION FOR ACTIVE MEMBERSHIP

AOA ID Number \_\_\_\_\_ Member Name \_\_\_\_\_

\_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last \_\_\_\_\_

\_\_\_\_\_ Suffix (Jr., Sr., etc.) \_\_\_\_\_ Designations (O.D., Ph.D., etc.) \_\_\_\_\_ Former/Maiden Names Used \_\_\_\_\_

### CONTACT INFORMATION

Preferred Mailing Address  Home  Business

#### Home Address

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Email \_\_\_\_\_

Telephone \_\_\_\_\_ Cell \_\_\_\_\_

**Business Address** (Note: If business name and address is not provided, the member will not appear in the AOA Doctor Locator website.)

Practice/Business Name \_\_\_\_\_

Address \_\_\_\_\_

Email \_\_\_\_\_

Telephone \_\_\_\_\_

Indicate primary \_\_\_\_\_ and secondary \_\_\_\_\_ practice settings from list below:  
(Your application will not be denied if you omit this question)

#### Self-Employed:

- A. Solo Practice Owner-(1 doctor **not affiliated** with a regional/national/local optical chain)
- B. Group Practice Owner-(2 or more doctors, **not affiliated** with a regional/national/ local optical chain)
- C. Solo Franchisee-(1 doctor **affiliated** with a regional/national optical chain)
- D. Group Franchisee-(Multiple doctors **affiliated** with a regional/national optical chain)
- E. Independent contractor/Lessee-(practice is **not affiliated** with a regional/national/local optical chain)
- F. Independent contractor/Lessee-(practice **is affiliated** with a regional/national/local optical chain)
- G. Multidisciplinary Practice Owner-(optometrist who is an owner of a practice in partnership with Ophthalmologists)

- I. Optometrist(s) **affiliated** with a regional/national optical company
- J. Ophthalmologist(s)
- K. HMO
- L. Hospital/Clinic/Other Multidisciplinary
- M. Community Health Center
- N. Regional/National Optical Company
- O. Armed Forces/VA/USPHS
- P. Educational Institution
- Q. Government or Indian Health Services
- R. Optical/Ophthalmic Manufacturer or Wholesaler
- S. Non-Optometry-owned independent Franchise/Optical
- T. Other employed by

#### Other:

- U. Fully Retired, no patient care
- V. Unemployed
- W. Non-optometry related career change

#### Employed by:

- H. Optometrist(s) **not affiliated** with a regional/national optical company

**Please complete Page 1 and Page 3 of this application. DO NOT COMPLETE PAGE 2 – that is for AOA and NHOA use only! Return the application to the NHOA office either by email or regular mail. It will be processed promptly.**

### Member Is

- New
  - Reinstated
  - Transferred From \_\_\_\_\_
- Effective Month of Membership** \_\_\_\_\_

### DEMOGRAPHIC INFORMATION

**Date of Birth** \_\_\_\_\_

(Your application will not be denied if you omit the two following questions (Gender/Ethnicity))

**Gender**  Male  Female

- Ethnicity**  White Caucasian
- Black African American  Hispanic
- Native American  Asian  Other

### Optometry School Attended

\_\_\_\_\_  
\_\_\_\_\_

**Year of Graduation** \_\_\_\_\_

### Licenses Obtained

Year	State
_____	_____
_____	_____
_____	_____

**NPI Number** \_\_\_\_\_

### Military Service

**Branch** \_\_\_\_\_

**Rank** \_\_\_\_\_

**Status**  Active  Reserve  Retired

### DUES OBLIGATION CALCULATION

Use the chart below to determine the 2017 annual dues obligation. No method of proration other than monthly as listed below is allowed. Members who have dropped and reinstated membership in the same year with the same affiliate must pay full year dues.

Effective Month of Membership \_\_\_\_\_ 2017 Annual Dues \$ \_\_\_\_\_



AOA ID Number \_\_\_\_\_ 2017 Dues Obligation \$ \_\_\_\_\_

Date Approved/By \_\_\_\_\_

Comments

**Additional Information:**

Your Undergraduate College:

Additional Degrees (other than O.D.): Bachelor's       Master's   
Ph.D.       Other:  (specify)

If you have completed an optometric RESIDENCY, check here (  ) and ATTACH A CERTIFICATE OF RESIDENCY COMPLETION.

HAS YOUR LICENSE TO PRACTICE EVER BEEN SUSPENDED OR REVOKED ANYWHERE? NO If yes, attach a statement with full details including all relevant official papers.

Your NH License #:                      Your spouse's name:

Your NHOA and AOA memberships are NOT contingent on your mode of practice or employment status.

From time to time, NHOA may release its membership list to people or companies who could provide you with information, or contact you. Please initial HERE (                      ) if you do NOT want your name released as a member of the NHOA to any outside source.

I hereby apply for membership in the New Hampshire Optometric Association. I agree to conform to the Constitution, By Laws, Code of Ethics and Standards of Conduct of the Association, copies of which are available on request from the NHOA office. Continued membership in the Association is contingent on this. Membership is voluntary and may be cancelled by either myself or the Association in accordance with the By Laws.

I understand that membership in the Association carries both rights and obligations, including the obligation to support the Association by timely payment of my dues and other financial obligations.

I certify that all information provided is true and complete. Any misrepresentation or misstatement of fact on this application shall cause it to be rejected, and you will not be eligible to re-apply for three years.

**Signature  
or Typed  
Name:**

**Date:**