Indiana OPTOMETRY | Indiana Optometric Association
275 N. Medical Drive, #3363
Carmel, IN 46082
(317) 237-3560
(317) 237-3564 (Fax)
www.ioa.org

Membership Application

(Visit https://www.ioa.org/membership.php for online form)

Last Name: ________________________ First Name: ____________________ Middle Name: ____________________

Maiden Name (If Applicable): _________________________ Nick Name (If Applicable): __________________________

Date of Birth: ____/_____/_____ Male / Female

Indiana License Number: __________________________ Year of Indiana Licensure: _________________________

Original State and Year of Licensure: ________________ Original License Number: _________________________

Other States/License Numbers:____

School of Optometry:______________________________ Month/Year O.D. Degree Obtained: _______/__________

Residency ☐Yes ☐ No Month/Year Completed ________/_________

Type of Application: ☐ New Member ☐ Reinstatement ☐ Transfer from __________________________________

Motivation to seek membership (check all that apply): ☐ Advocacy ☐ CE ☐ Optometric Resources ☐ Social Networking ☐ Exploration of Career Options ☐ Discounts from Partner Organizations

Office Contact Information:

Business Name (If Applicable): ____

Office Street Address: ______________________________ City: ___________________________ State: ________

Zip Code: ___________ County: __________________ Office Email: ___________________________________

Office Phone: (______)_____________________________ Office FAX: (_____)______________________________

Home Contact Information:

Spouse's Name (If Applicable): ____

Home Street Address: _______________________________ City: ________________ State: ________

Zip Code: ___________ County: __________________ Home Email: __________________________________

Home Phone: (______)____________________________ Mobile Phone (_____)__________________________

Mailing Address Preference: ☐Office ☐Home
Email Preference: ☐Office ☐Home
Phone Contact Preference ☐Office ☐Home ☐Mobile

I certify that I am duly licensed to practice optometry in the State of Indiana. If my application is approved, I promise to fully support the Constitution, Bylaws and Code of Ethics of the Indiana Optometric Association, Inc., and the American Optometric Association. I understand that my membership will be subject to termination should I violate the provisions of the above-mentioned Constitutions, Bylaws or Codes of Ethics in any way.

Applicant's Signature: _____________________________________ **Date:** _________________

Please return to:

Indiana Optometric Association
275 N. Medical Drive, #3363
Carmel, IN 46082
Fax: (317) 237-3564

IOA Local Society Use Only:

This application was ***APPROVED / DISAPPROVED*** (circle one)

by the ___________________________ Society on ____________, 20___,

____
(Signature of Society President or Secretary-Treasurer)

Version 02/21