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: (_____)_____

Please circle one: **Full Time or Part Time (less than 16 hours)**

IOA Dues Billing Preference: **Monthly, Quarterly, or Annual** ***(Please note, monthly and quarterly options require account to be set up on autopay)***

Home Contact Information:

Spouse's Name (If Applicable): _____

Home Street Address: _____ City: _____ State: _____

Zip Code: _____ County: _____ Home Email: _____

Home Phone: (_____)_____ Mobile Phone (_____)_____

Please do not provide a student email address (addresses ending in ".edu")

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:
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275 N. Medical Drive, #3363
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