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

Partial Practice Membership Application

A member in good standing who works sixteen (16) hours or less per week in compensated activities related to the practice of optometry may be granted a Partial Practice Membership subject to an annual renewal. An application for a Partial Practice Membership must be approved by the Local Society, Board of Trustees and House of Delegates. If Partial Practice Membership is approved, a similar request by the Board of Trustees will be made to the American Optometric Association.

APPLICANT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Home Street Address: _____ City: _____ State: _____

Zip Code: _____ County: _____ Home Email: _____

Home Phone: _____ Mobile Phone: _____

EMPLOYMENT INFORMATION

Office Contact Information (If Applicable)

Business Name: _____

Office Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Office Phone: _____ Office Email: _____ Office Fax: _____

COMPENSATED ACTIVITY RELATED TO THE PRACTICE OF OPTOMETRY

How many hours per week do you work? _____

Please describe the nature of your current practice or employment and the reasons for your request for partial practice membership status. Additional information or documentation may be requested by the IOA or your local society in order to review your request.

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ADDITIONAL INFORMATION

In order for your application to be reviewed by the Board of Trustees during it's February meeting and the House of Delegates, which meets once per year in April, ***please submit your application and any supporting documentation to the IOA at the address listed above NO later than January 31.*** Your application will be shared with your local society.

SIGNATURE

By my signature affixed below, I attest that the information provided is factual and does not contain any misleading or incorrect information that would influence the approval of the Partial Practice Membership Application.

Signature of Applicant: _____ Date: _____

Reviewed by Local Society: Yes: _____ No: _____ Local Society Approved: Yes: _____ No: _____

Local Society Authorized Signature: _____ Date: _____

Application Approved by Board of Trustees: Yes: _____No: _____ Date: _____

Application Approved by House of Delegates: Yes:_____No: _____ Date: _____

Version 06/23