Application for Associate Membership

Associate Members of this Association shall be optometrists licensed in, but not practicing in South Carolina, who are members of their state AOA affiliate or of the Armed Forces of Optometry.

Full Name: ____________________
(Last, First, Middle)

Marital Status: ☐ Single ☐ Married **Sex:** ☐ Male ☐ Female

Date of Birth: ____________________ **Ethnicity:** ____________________

Maiden Name (if applicable): ____________________ **Spouse** (if applicable): ____________________

AOA Number: ____________________ **Are you a member of AFOS?:** ☐ Yes ☐ No

Home Address:

Street: ____________________

City: ____________________ State: __________ Zip Code: ____________________

County: ____________________

Home Phone: ____________________ Cell: ____________________

Personal E-mail Address: ____________________

Name of Practice(s): ____________________

Practice Address: (If multiple practices, please list primary address)

Street: ____________________

City: ____________________ State: __________ Zip Code: ____________________

County: ____________________

Practice Phone Number: ____________________

Practice E-mail Address: ____________________

Which address would you prefer to receive mail: ☐ Home ☐ Practice

Which address would you prefer to receive e-mail: ☐ Personal ☐ Practice

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Practice Website: ____________________

Preferred Method of Social Networking: ☐ Facebook ☐ Twitter ☐ Other: ____________________

Education:

Undergraduate Attended:____

Graduation Year:____

Optometry School Attended: ____

Graduation Year:____

Residency (if applicable):____

NPI Number:__________________ **Primary License #:**__________________ **Received:**_____ / _____
(month/year)

Please list any other states you are licensed in, along with your license number:

____

I would be interested in serving on the following:
(Check all that apply)

- ☐ **Legislative Committee**
- ☐ **3rd Party Insurance Committee**
- ☐ **Public Relations Committee**
- ☐ **Membership Committee**

SCOPA Interests: (Check all that apply)

- ☐ **Legislature**
- ☐ **3rd Party Insurance**
- ☐ **Public Relations / Social Networking**
- ☐ **Continuing Education**
- ☐ **Networking with Colleagues**
- ☐ **Annual Meeting**
- ☐ **Spring Meeting**
- ☐ **Social Events**
- ☐ **SC Special Olympics**
- ☐ **Community Events**

Please provide a brief explanation of why you are interested in joining the SCOPA as an associate member:

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SCOPA Mission Statement

Preserve, promote and advance the profession of optometry
ensuring access to quality eye care in South Carolina.

For SCOPA STAFF USE:
Date Rec'd ____/____ Date Approved ____/____

BOD Meeting approved: ___________________

AOA Approval: ___________________________

Visit us on the online at:

- www.sceyedoctors.com
- **Facebook**: SCOPA on FB (private) & SC Optometric Physicians Association Page
- **Instagram**: @scopaeyedocs

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