

Application for New Graduate Membership



Please check which applies:

- Resident
- Graduated from optometry school in the past year

Full Name: _____
(Last, First, Middle)

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

Date of Birth: _____ **Ethnicity:** _____

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

Home Address:

Street: _____

City: _____ State: _____ Zip Code: _____

County: _____

Home Phone: _____ Cell: _____

Personal E-mail Address: _____

Name of Practice(s) or Residency Program: _____

Practice or Residency Program Address: (If multiple, please list primary address)

Street: _____

City: _____ State: _____ Zip Code: _____

County: _____

Phone Number: _____

E-mail Address: _____

Which address would you prefer to receive mail: Home Practice

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

Practice Website: _____

Preferred Method of Social Networking: Facebook Twitter Other: _____

Education:

Undergraduate Attended: _____

Graduation Year: _____

Optometry School Attended: _____

Graduation Year: _____

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)

- | | |
|--|---|
| <input type="checkbox"/> Legislative Committee | <input type="checkbox"/> SCOPA Board of Directors |
| <input type="checkbox"/> 3 rd Party Insurance Committee | <input type="checkbox"/> Local Society Leadership |
| <input type="checkbox"/> Public Relations Committee | <input type="checkbox"/> Leadership Institute |
| <input type="checkbox"/> Membership Committee | |

SCOPA Interests: (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Legislature | <input type="checkbox"/> Annual Meeting |
| <input type="checkbox"/> 3 rd Party Insurance | <input type="checkbox"/> Spring Meeting |
| <input type="checkbox"/> Public Relations / Social Networking | <input type="checkbox"/> Social Events |
| <input type="checkbox"/> Continuing Education | <input type="checkbox"/> SC Special Olympics |
| <input type="checkbox"/> Networking with Colleagues | <input type="checkbox"/> Community Events |

Do you plan on staying in SC after graduating? Yes No If no, please list which state: _____

Please provide a brief explanation of why you are interested in joining the SCOPA and/or AOA:

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