Application for Membership

Please check which applies:

- ☐ Initial Membership
- ☐ Rejoining
- ☐ State Transferred from _____

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): _____

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 Board of Directors**
- ☐ **Local Society Leadership**
- ☐ **Leadership Institute**

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 or transferring your membership from another state affiliate Association:

_____

_____

_____

_____

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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