The Cleveland Ophthalmological Society

Membership Application

I, THE UNDERSIGNED, HEREBY APPLY FOR MEMBERSHIP IN THE CLEVELAND OPHTHALMOLOGICAL SOCIETY

FULL NAME:____DEGREE:________
CURRENT PRACTICE AFFILIATION: ____
SUB-SPECIALTY:____

OFFICE ADDRESS: ____
OFFICE PHONE NUMBER:____
CELL PHONE NUMBER:____
EMAIL ADDRESS FOR ALL COS COMMUNICATION: ____

ASSISTANT NAME: ____
ASSISTANT EMAIL ADDRESS: ____
ASSISTANT PHONE NUMBER: ____

MEDICAL SCHOOL: ____GRADUATED: ______
INTERNSHIP:____FROM ____ TO _____
RESIDENCY:____ FROM ____ TO _____
FELLOWSHIP:____FROM ____ TO _____

CERTIFIED BY THE AMERICAN BOARD OF OPHTHALMOLOGY: YES OR NO AS OF YEAR: _______
ANTICIPATED YEAR: _______

PRACTICE LIMITED TO: ____

APPLICANT SIGNATURE: ____**DATE**_________________

APPLICATN MUST BE SPONSORED BY TWO ACTIVE MEMBERS OF COS (SIGNATURES TO BE OBTAINED BY APPLICANT AT 1ST ATTENDED MEETING)

RECOMMENDED FOR MEMBERSHIP BY:

1. ____DATE________
2. ____DATE________

COS BOARD APPROVAL:

Reading/Elected Date: _____
Notified Date: ____________