



# American Association of Certified Orthoptists


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## Membership Application

Please provide the information requested below and return with your application fee to:  
 AACO, 10 W. Phillip Rd., Suite 120, Vernon Hills, IL 60061.

**Application fee:** applied to first year of dues  
 Active & Associate \$150.00 (No fee for newly certified orthoptist)  
 Student \$50

**PLEASE PRINT**

<b>Applicant's name</b> <i>enter here</i> 	_____
<b>Certifications - check all that apply</b>	<input type="checkbox"/> CO <input type="checkbox"/> OC(C) <input type="checkbox"/> DBO <input type="checkbox"/> COMT <input type="checkbox"/> Other _____
<b>Membership Category</b> (check one)	<input type="checkbox"/> Active <input type="checkbox"/> Associate <input type="checkbox"/> Student <input type="checkbox"/> <i>Check here if newly certified</i>
<b>PRACTICE INFORMATION</b>	
Practice / Clinical Name	_____
Office Mailing address	_____
City/State/Zip	_____
Office phone	_____
Office fax	_____
<b>HOME INFORMATION</b>	
Street	_____
City/State/Zip	_____
Home phone	_____
Cell phone	_____
<b>Country:</b>	_____
<b>Preferred Email:</b> (very Important!)	_____
<b>Preferences:</b> Mailing address: Information delivery:	<input type="checkbox"/> Office <input type="checkbox"/> Home <input type="checkbox"/> Regular mail <input type="checkbox"/> Email
<b>Sponsoring Ophthalmologist:</b>	_____
<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Year of Certification:</b> _____
<b>Orthoptic Program:</b>	_____

Please finish by completing the payment information on the next page . . .

<i>For Office Use Only</i>		
Date received	_____	_____
Application fee paid	_____	_____
Final approval	_____	_____

