



American Association of Certified Orthoptists

10 W. Phillip Rd., Suite 120 ♦ Vernon Hills, IL 60061-1730 ♦ (847) 680-1666 ♦ Fax: (847) 680-1682


Email: Rich@orthoaptics.org ♦ Web: www.orthoaptics.org

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 - \$200.00 (\$100 for newly certified orthoptist)
 Student - No fee

PLEASE PRINT

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

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

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

Payment Information

Applicant's name: _____

Amount enclosed: \$ _____

Form of Payment: Check (payable to "American Association of Certified Orthoptists")
 Visa MasterCard Discover American Express

Credit Card #

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 Exp. Date

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Security Code (on back of card)

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Name on card: _____

Billing address: _____

Signature _____

Send application along with application fee check or credit card information to:
American Association of Certified Orthoptists
Administrative Office
10 W. Phillip Rd., Suite 120
Vernon Hills, IL 60061-1730