



INDIANA ACADEMY OF OPHTHALMOLOGY  
APPLICATION FOR MEMBERSHIP  
(PLEASE PRINT OR TYPE)

NAME: \_\_\_\_\_ DEGREE(S): \_\_\_\_\_  
(First) (Middle Initial) (Last)

**PRIMARY OFFICE LOCATION:**

PRIMARY PRACTICE NAME: \_\_\_\_\_

PRIMARY OFFICE ADDRESS: \_\_\_\_\_

CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

OFFICE PHONE: ( ) \_\_\_\_\_ FAX NUMBER: ( ) \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

PRIMARY OFFICE CONTACT PERSON: \_\_\_\_\_

**OTHER OFFICE LOCATIONS:**

(Additional practice locations listed will be included on the Find An EyeMD section of the website)

#2 PRACTICE NAME: \_\_\_\_\_

OFFICE ADDRESS: \_\_\_\_\_

CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

OFFICE PHONE: ( ) \_\_\_\_\_

#3 PRACTICE NAME: \_\_\_\_\_

OFFICE ADDRESS: \_\_\_\_\_

CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

OFFICE PHONE: ( ) \_\_\_\_\_

#4 PRACTICE NAME: \_\_\_\_\_

OFFICE ADDRESS: \_\_\_\_\_

CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

OFFICE PHONE: ( ) \_\_\_\_\_

#5 PRACTICE NAME: \_\_\_\_\_

OFFICE ADDRESS: \_\_\_\_\_

CITY/STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

OFFICE PHONE: (    ) \_\_\_\_\_

**PERSONAL INFORMATION:**

RESIDENCE ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: (    ) \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SPOUSE'S NAME: \_\_\_\_\_

ARE YOU A VETERAN:  YES     NO    Military Branch: \_\_\_\_\_

**LICENSURE AND EDUCATION:**

REQUIREMENTS:    I am a currently licensed physician in my primary state    \_\_\_\_\_ Yes    \_\_\_\_\_ No  
Primary State License Number \_\_\_\_\_

MEDICAL SCHOOL: \_\_\_\_\_ YEAR OF GRADUATION: \_\_\_\_\_

DATE & LOCATION OF:    INTERNSHIP: \_\_\_\_\_

RESIDENCY: \_\_\_\_\_

FELLOWSHIP: \_\_\_\_\_

**PRACTICE INFORMATION:**

PRACTICE FOCUS: (Up to 6 may be selected)

- |   |   |
|---|---|
| <input type="checkbox"/> CATARACT             | <input type="checkbox"/> OCULOPLASTIC         |
| <input type="checkbox"/> COMPREHENSIVE        | <input type="checkbox"/> PEDIATRIC/STRABISMUS |
| <input type="checkbox"/> CORNEA/EXTERNAL DIS. | <input type="checkbox"/> REFRACTIVE           |
| <input type="checkbox"/> GLAUCOMA             | <input type="checkbox"/> RETINA/VITREOUS      |
| <input type="checkbox"/> PATHOLOGY            | <input type="checkbox"/> UVEITIS              |
| <input type="checkbox"/> NEURO-OPHTHALMOLOGY  | <input type="checkbox"/> OTHER                |

DATE BEGAN PRACTICING OPHTHALMOLOGY: \_\_\_\_\_

CERTIFIED BY THE AMERICAN BOARD OF OPHTHALMOLOGY: \_\_\_\_\_ (DATE)

I AM BOARD ELIGIBLE: \_\_\_\_\_ (DATE OF EXPIRATION OF ELIGIBILITY)  
(BOARD CERTIFICATION OR ELIGIBILITY ARE NOT REQUIRED FOR MEMBERSHIP)

**MISCELLANEOUS INFORMATION:**

PREFERRED METHOD OF COMMUNICATION:  Email     Fax

**RECOMMENDED FOR MEMBERSHIP BY:**

\_\_\_\_\_, M.D.  
Signature

\_\_\_\_\_, M.D.  
Signature

\_\_\_\_\_, M.D.  
Printed Name

\_\_\_\_\_, M.D.  
Printed Name

(Application must include the signatures of two (2) active members of the Indiana Academy of Ophthalmology, Inc.)

**FEES:**

<b>(X)</b>	<b>Member Level</b>	<b>Description</b>
<input type="checkbox"/>	\$795 Advocate Fellow	Indiana licensed physicians practicing ophthalmology in good standing with the IAO, make a contribution to the EyePAC (suggested contribution is \$365), agree to participate in legislative/lobbying activities of the IAO, agree to send at least 1 letter annually to Congressional or State representative. Advocate members will receive enhanced IAO member benefits. \$_____ Advocate Fellow PAC Contribution - (Suggested amount is \$365)
<input type="checkbox"/>	\$795 Fellow	Indiana licensed physicians practicing ophthalmology.
<input type="checkbox"/>	\$250 Junior Fellow	Indiana licensed physicians practicing ophthalmology for less than 2 years
<input type="checkbox"/>	\$250 Senior Fellow	Indiana licensed physicians who have reached their 66 <sup>th</sup> birthday and are still practicing ophthalmology.
<input type="checkbox"/>	\$100 Resident	Physicians enrolled in approved ophthalmology residency training programs in Indiana.
<input type="checkbox"/>	\$0 Retired	Former Fellows of the IAO who are retired.
<input type="checkbox"/>	\$150 Out-of-State	Licensed physicians practicing ophthalmology. They must be members of the state society of their primary office location. \$_____ Other PAC Contribution

\*Contribution to Indiana EYEPAC MUST be made via **personal** check or **personal** credit card.

**PAYMENT METHOD:**

Check (payable to IAO)

Credit Card (Visa or MasterCard)

Credit Card Account Number \_\_\_\_\_

Security Code: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
(last three or four digits on back of card)

Name Of Card Holder: \_\_\_\_\_

Credit Card Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature Of Card Holder: \_\_\_\_\_

Contributions or gifts to the IAO are not tax deductible as charitable contributions for federal income tax purposes. However, dues payments (except for specific governmental affairs expenses) may be deducted as a professional or business expenses, to the extent allowable by law.

I certify that I meet the above-listed criteria established for the category of membership for which I am applying.

**Indiana EYEPAC Contribution Payment**

Check (payable to IAO)

Credit Card (Visa or MasterCard)

Credit Card Account Number \_\_\_\_\_

Security Code: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
(last three or four digits on back of card)

Name Of Card Holder: \_\_\_\_\_

Credit Card Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature Of Card Holder: \_\_\_\_\_

I understand that by providing my organization’s mailing address, e-mail address, telephone number, and fax number, I hereby consent, on behalf of my organization, to receive any and all communications sent by or on behalf of the Indiana Academy of Ophthalmology via regular mail, e-mail, telephone, or fax to the mailing address, e-mail address, telephone number, and fax number listed above. I hereby represent that I have the authority on behalf of my organization to consent to receive such communications. I understand that the Indiana Academy of Ophthalmology may share my address/e-mail/telephone/fax with other organizations.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

For questions, please contact Kim Williams, MBA, Executive Director, at (317) 577-3062 or via email at [IAO@IndianaEyeMDs.com](mailto:IAO@IndianaEyeMDs.com)

Please return this form with payment to:

Indiana Academy of Ophthalmology, Inc. ♦ 8766 South Street, Suite 130 ♦ Fishers, Indiana 46038  
♦ Ph: (317) 577-3062 ♦ Fax: (866) 388-1057 ♦ Email: Info@IndianaEyeMDs.com

## IAO MEMBER BENEFITS

### IAO ACTIVE MEMBER BENEFITS

**AV Library** - Slides, videos, PowerPoint presentations and audiocassettes for loan.

**Educational Programs** - Programs with continuing education credits for members, ophthalmic practice administrators, office managers, insurance personnel, ophthalmic technicians, and nurses.

**Legislative/Regulatory Advocacy and PAC** - The IAO retains a lobbyist to represent you and your practice. The IAO administers the Indiana Academy of Ophthalmology Political Action Committee (PAC).

**Patient Referral** - IAO member names are referenced when members of the public inquire about finding an ophthalmologist.

**Publications** – IAO fax newsletters *Eyeball-to-Eyeball* and *Eyes on the Legislature*.

**Public Relations Campaigns** - The IAO promotes the profession of ophthalmology, and IAO members in particular, through attendance at numerous health fairs and exhibits and through the use of media releases.

**Reimbursement Consulting and Seminars** - The IAO utilizes Help Forms to assist members with third party reimbursement questions. Ten questions per member per year submitted on our help form are answered at no cost to the member. The IAO sponsors coding seminars on Medicare, Medicaid, and practice management issues around the state for members and their staff on the latest rules and regulations. IAO members receive member-only rates on all IAO sponsored meetings and seminars.

**Third Party Advocacy** - The IAO maintains contact with all major third party payers in the state.

**Voice in the AAO** - IAO members gain a collective voice in policy development and programs with the American Academy of Ophthalmology through the Council representative.

### IAO ADVOCATE FELLOW ENHANCED MEMBER BENEFITS

All benefits of active IAO members plus:

- IAO Advocate and PAC ribbons at the IAO Annual Meeting
- Special recognition at IAO functions
- 10 additional IAO Help Forms per year
- Receive email copies of the weekly IAO Legislative Update during the Legislative Session
- Receive email of any additional legislative information sent to the Legislative Committee during the Interim of the Legislature
- Quarterly PAC contributor newsletter
- Opportunity to have all IAO member publications and special mailing (i.e., *Eyeball-to-Eyeball*) sent to another designated staff (must be approved by the Legislative Committee/cannot be a non-member of the IAO)
- Designation as a Advocate Member on the IAO Website *Find An Eye MD* section