Maine Society of Eye Physicians and Surgeons
Application for Membership

Date:____

I, THE UNDERSIGNED, HEREBY APPLY FOR MEMBERSHIP IN THE MAINE SOCIETY OF EYE PHYSICIANS AND SURGEONS:

Name:____ MD or DO (Please Circle)

Office Address:____ Telephone #:_________________
Fax #: ______________________

Home Address:____ Telephone #:_________________
Fax #: ______________________

E-Mail Address:____

Graduate of ____ Medical School Year:_________

Internship:____ From:_________ To:_________

Residency and/or Post Graduate Training:

____ From:_________ To:_________
____ From:_________ To:_________
____ From:_________ To:_________

Certified by the American Board of Ophthalmology (Yes or No)_________ Year:_________

Certified by the American Board of Osteopathic Ophthalmology and Otolaryngology (Yes or No)_________ Year:_________

Signed:____

Applicant must be sponsored by two active members of the Maine Society of Eye Physicians and Surgeons
(Signatures to be obtained by applicant)

Recommended for Membership by:

1. ____ Date:_________________________
2. ____ Date:_________________________

Reading of Application Date:______________________________

Elected to Membership: ________ Yes ________ No