

**For Public Information on the WAEPS Website**

Name \_\_\_\_\_ Suffix \_\_\_\_\_ (example, MD/DO, PhD, etc.)

Practice Name \_\_\_\_\_ Referred by \_\_\_\_\_

Practice Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Practice Phone \_\_\_\_\_ Practice Fax \_\_\_\_\_ Website \_\_\_\_\_

General Practice Information Email Address for Patients \_\_\_\_\_

■ **Second Practice Location**

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

■ **Certification/License**

Board Certified in Ophthalmology by the American Board of Ophthalmology:

Yes  No  Eligible (just out of residency) Date Certified: \_\_\_\_\_

WA State License to Practice Ophthalmology?  Yes  No Date: \_\_\_\_\_

■ **Education**

Medical School \_\_\_\_\_ Institution, location \_\_\_\_\_ Dates \_\_\_\_\_ Residency \_\_\_\_\_ Institution, location \_\_\_\_\_ Dates \_\_\_\_\_

Internship \_\_\_\_\_ Institution, location \_\_\_\_\_ Dates \_\_\_\_\_ Fellowship \_\_\_\_\_ Institution, location \_\_\_\_\_ Dates \_\_\_\_\_

Internship \_\_\_\_\_ Institution, location \_\_\_\_\_ Dates \_\_\_\_\_ Postgraduate \_\_\_\_\_ Institution, location \_\_\_\_\_ Dates \_\_\_\_\_

Hospital Affiliations: \_\_\_\_\_

Memberships in County, State, National Societies: \_\_\_\_\_

■ **Patient Information**

Languages Spoken in Practice: \_\_\_\_\_

• Accepting New Patients:  Yes  No • Accepts Most Insurances:  Yes  No

• Accept Medicare:  Yes  No • Accept Medicaid:  Yes  No

Insurance Comments: \_\_\_\_\_

Practice Philosophy: \_\_\_\_\_

**Member Only Directory Information**

Preferred Email Address \_\_\_\_\_ Alternate Email Address \_\_\_\_\_

Private Phone Line \_\_\_\_\_ Pager Number \_\_\_\_\_ Cell Number \_\_\_\_\_

Home Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ My preferred mailing address for WAEPS business is:  Home  Practice

Practice Manager Name \_\_\_\_\_ Practice Manager Direct Line \_\_\_\_\_

Practice Manager Email \_\_\_\_\_  I authorize Practice Manager to receive WAEPS Communications

■ **Subspecialties** (for Physician and Patient Referrals). *Check as many that apply.*

- |  |   |   |  |  |
|--|---|---|--|--|
| <input type="checkbox"/> Anterior Segment        | <input type="checkbox"/> Glaucoma               | <input type="checkbox"/> Occupational Ophthalmology | <input type="checkbox"/> Pediatric Ophthalmology | <input type="checkbox"/> Retina/Vitreous Surgery |
| <input type="checkbox"/> Cataract/IOL            | <input type="checkbox"/> Comprehensive Eye Care | <input type="checkbox"/> Ocular Oncology            | <input type="checkbox"/> Plastics/Reconstructive | <input type="checkbox"/> Strabismus              |
| <input type="checkbox"/> Cornea/External Disease | <input type="checkbox"/> Low Vision Rehab       | <input type="checkbox"/> Optics/Refraction          | <input type="checkbox"/> Pathology               | <input type="checkbox"/> Trauma                  |
| <input type="checkbox"/> Craniofacial Surgery    | <input type="checkbox"/> Medical Retina         | <input type="checkbox"/> Ophthalmic Surgery         | <input type="checkbox"/> Refractive Surgery      | <input type="checkbox"/> Ultrasound              |
| <input type="checkbox"/> Contact Lenses          | <input type="checkbox"/> Neuro-Ophthalmology    | <input type="checkbox"/> Ophthalmic Pathology       | <input type="checkbox"/> Ophthalmic Research     | <input type="checkbox"/> Uveitis/Immunology      |

■ **Member Categories**

- **Active:** A physician who holds a MD or DO degree or equivalent, who holds a valid and unrestricted license to practice medicine in Washington State, and who has been certified or is eligible to be certified by the American Board of Ophthalmology.
- **Associate:** A physician who holds a MD or DO degree or equivalent, who holds a valid and unrestricted license to practice medicine in the State of Washington, and who has satisfactorily completed an entire program of formal residency training in ophthalmology, or who is not an ophthalmologist but is engaged in a field allied with or in a basic science related to ophthalmology, or a person who, in the judgment of the Board of Trustees, has made significant contributions to ophthalmology. Associates shall not have the right to vote and shall be ineligible to hold office.
- **Senior:** A previous Active member who remains in active practice and whose license to practice medicine is valid and unrestricted after having reached the age of 65 and engaged in the practice of ophthalmology for a period of 25 years, and who has been a member of this Academy for five or more years.
- **Military:** A physician who holds a MD or DO degree or equivalent, and serves full time in active duty with any branch of the U.S. Military Service.
- **Emeritus:** A physician who is no longer engaged in the active practice of ophthalmology by reason of disability or retirement and whose license to practice medicine was valid and unrestricted at the time of disability or retirement, and who has held active membership for five or more years is eligible to become an Emeritus Fellow. Emeritus fellows shall not have the right to vote and shall be ineligible to hold office.
- **Resident:** A physician who holds a MD or DO degree or equivalent, and who is engaged on a full-time basis in an ophthalmology residency training program, or who has satisfactorily completed such a training program and is engaged on a full-time basis either in an ophthalmology fellowship training program or in a postgraduate educational course of training leading to an advanced degree at an accredited college or university, or a foreign medical graduate who is otherwise not eligible for membership and is engaged on a full-time basis in a postgraduate ophthalmology training program. Resident members shall not have the right to vote and shall be ineligible to hold office.

■ **Dues Structure**

- |   |               |                                      |
|---|---------------|--------------------------------------|
| <input type="checkbox"/> First Year Active Member (first year of practice in WA State)    | <b>\$340</b>  | (\$170 Dues + \$170 Standard EyePAC) |
| <input type="checkbox"/> First Year Associate Member (first year of practice in WA State) | <b>\$340</b>  | (\$170 Dues + \$170 Standard EyePAC) |
| <input type="checkbox"/> Active Member (practicing in WA State for more than 1 year)      | <b>\$975</b>  | (\$675 Dues + \$300 Standard EyePAC) |
| <input type="checkbox"/> Associate Member (practicing in WA State for more than 1 year)   | <b>\$975</b>  | (\$675 Dues + \$300 Standard EyePAC) |
| <input type="checkbox"/> Senior Member  | <b>\$470</b>  | (\$170 Dues + \$300 Standard EyePAC) |
| <input type="checkbox"/> Military Member  | <b>\$450</b>  | (\$150 Dues + \$300 Standard EyePAC) |
| <input type="checkbox"/> Emeritus Member  | <b>\$200</b>  | (\$100 Dues + \$100 Standard EyePAC) |
| <input type="checkbox"/> Resident   | <b>Waived</b> |                                      |
- I choose not to support WAEPS legislative efforts to maintain the highest quality eye care or help ensure that surgery is performed only by medical or osteopathic surgeons by contributing to the Physicians EyePAC. I opt to pay WAEPS membership dues only.

■ **Total Amount Enclosed** \_\_\_\_\_

- Check enclosed (Made payable to **WAEPS**) MAIL TO: 2033 Sixth Ave., Ste. 1100, Seattle, WA 98121
- Charge my Credit Card:  Visa  MasterCard  AMEX FAX TO: 206-441-5863 (if paying by credit card)

Credit Card # \_\_\_\_\_ Expiration Date \_\_\_\_\_

Name on Card (please print) \_\_\_\_\_ Signature \_\_\_\_\_

Street Address of Card \_\_\_\_\_ Zip Code \_\_\_\_\_