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