Indiana Optometric Association
275 N. Medical Drive, #3363, Carmel, IN 46082
317-237-3560 • FAX 317-237-3564

Associate Membership Application (non-OD)

Associate membership in the Indiana Optometric Association, doing business as Indiana Optometry, is for individuals not licensed to practice optometry who have a substantial interest in the profession of optometry and who contribute to the advancement of the objects of this association. Memberships are in the name of the individual, rather than in the name of a company or corporation. Payment of $400.00 annual dues must be submitted with your application. Payments received after September 30 will be applied to membership for the following year.

(Please type or print)

Full Name of Applicant: _____

Business/Organization Name/ Your Title_____

Street Address or PO Box_____

City_____State_____Zip Code_____

Office Phone_____/_____Fax_____/_____

Email Address_____

Do you have a professional license or certificate? ☐ Yes ☐ No

If yes, what is the profession in which you hold a license? _____

In what state do you hold this license? _____

Please indicate the nature of your or your organization's business
(Check all that apply)

- ☐ Optometric Lab
- ☐ Optometric Manufacturer
- ☐ Optometric Supplier or Distributor
- ☐ Optometric Educator
- ☐ Employer of Optometrists
- ☐ Optometric Co-Management Organization
- ☐ Independent Representative
- ☐ Ophthalmologist
- ☐ Other_____

Home Address:
Street Address or PO Box_____

City_____State_____Zip Code_____

Home or Cell Phone _____/_____

I certify that the information above is accurate and true. I further certify that, upon acceptance of membership, I will fully support IOA's Constitution and By-Laws and the Code of Ethics.

Signature_____ Date_____

Please return completed application to:
Indiana Optometry, 275 N. Medical Dr., #3363, Carmel, IN 46082 or Fax to: 317-237-3564

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____ **Paying by VISA/MasterCard (we do not accept American Express or Discover)**

____ **Check is enclosed in the amount of $_____ (Make checks payable to the Indiana Optometric Association)**

CREDIT CARD INFORMATION

	Type (Visa, MC)	Account/Card Number	Expires (Month/Year)
Credit Card			
Name on Card (PRINT)			Amount $

I hereby authorize the above amount to be charged >

Signature: _____ **Date:** _____