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WISCONSIN OPTOMETRIC ASSOCIATION

Affiliated with American Optometric Association

6510 Grand Teton, Suite 312 • Madison, WI 53719-1288 • Phone: (608) 824-2200 • In-State: (800) 678-5357

MEMBERSHIP APPLICATION

TO PROSPECTIVE MEMBERS:

Please:

_____1. Complete and sign copy of the application. Retain one copy for your files if you wish.

_____2. Mail the application and your check(s) for dues per attached schedule* to:

Wisconsin Optometric Association
6510 Grand Teton Plaza, Suite 312
Madison, Wisconsin 53719

* Full payment for annual dues must accompany the application. These may be paid with one check for the full amount, four checks dates January 1, April 1, July 1, and October 1 or twelve checks dated the first day of each month. In any case, all checks must accompany your application for membership. Dues payments for the full amount may also be made via Mastercard or Visa.

CRITERIA OF MEMBERS, WOA BYLAWS

Section 1. The criteria for securing and maintaining membership in this Association are as follows: (1) maintenance of a current and valid license to practice optometry in Wisconsin; (2) adhere to the rules, regulations and restrictions imposed by the licensing body in Wisconsin: (3) willingness to serve or otherwise participate as reasonably suggested by the Association in activities relating to the Association, the practice of optometry and the public welfare in relation to the practice of optometry; (4) conduct the practice of optometry so as to avoid bringing discredit individually or collectively upon optometrists or optometry; (5) pay all dues and assessments levied by this association; (6) maintain membership in a component of this Association based on these criteria; (7) if employed, associated or otherwise involved in any way which directly or indirectly relates to the practice of optometry by or with any third party entity or person except one licensed to practice optometry in the State of Wisconsin, then insuring that such involvement does not negatively affect the quality, scope, nature or extent of the optometric practice or services delivered; (8) adhere to the Code of Ethics described in Article XVIII; (9) affirm by signature on dues billing forms upon payment of annual dues, that such active full-time practicing member has attended and successfully completed courses amounting to a minimum of fifteen (15) hours of continuing education within the previous year, (10) member in good standing in the American Optometric Association.

Section 2. The Certificate of Membership shall at all times remain the property of the Association and must be returned to the Secretary if at any time the holder ceases to be a member of the Association.

THE VISION OF THE WOA

The Wisconsin Optometric Association assists Doctors of Optometry in providing state of the art eye care to benefit their patients and communities. This goal is accomplished by continuous outreach, advocacy and education for the benefit of our members and their patients.

THE WOA MISSION STATEMENT

"The Wisconsin Optometric Association is a nonprofit affiliation of licensed optometrists and associated businesses dedicated to the preservation and enhancement of the vision welfare of the people of Wisconsin.

The Wisconsin Optometric Association exists to benefit every citizen through the development and delivery of cost effective, high-quality, 'state of the art' eye care equally available to everyone; and to maintain high technical and professional standards by all optometrists in all endeavors."

The Wisconsin Optometric Association accomplishes this by:

- *Education and dissemination of information to its members and the general public;*
- *Organized governmental activity;*
- *Mediation with consumer and public interest groups; and*
- *Providing collective benefits to members.*

THE CODE OF ETHICS OF THE WISCONSIN OPTOMETRIC ASSOCIATION

It shall be the ideal, the resolve and the duty of the members of the Wisconsin Optometric Association:

- To keep the visual welfare of the patient uppermost at all times;
- To promote in every possible way, in collaboration with this Association, better care of the visual needs of humankind;
- To enhance continuously their educational and technical proficiency to the end that their patients shall receive the benefits of all acknowledged improvements in visual care;
- To see that every person receive appropriate vision and eye health care, regardless of financial status
- To advise the patient whenever consultation with an optometric colleague or reference for other professional care seems advisable;
- To hold in professional confidence all information concerning a patient and to use such data only for the benefit of the patient;
- To conduct themselves as exemplary citizens;
- To maintain their offices and their practices in keeping with the professional standards;
- To maintain and promote positive relationships with members of their own profession and of other professions for the interchange information to the advantage of their patients.

Date_____

TO: BOARD OF DIRECTORS
WISCONSIN OPTOMETRIC ASSOCIATION

Being duly licensed to practice optometry in Wisconsin I do hereby make application for membership in the Wisconsin Optometric Association.

BIOGRAPHICAL INFORMATION:

Name in full _____ Date of birth _____

I prefer to receive information from the WOA via: ___Email ___Regular Mail

I prefer to receive mail at: ___Office#1 ___Office #2 ___Home (Please check one)

Email Address: _____

Home Address:

Address

City State Zip

Phone FAX

Optional Information:

Sex: _____ Marital Status: _____

Spouse Name: _____

Number of Children: _____

Office (#1) Address:

Company/Practice/Group Name

Address

City State Zip

Phone FAX

M T W Th F Sa Sn

Office (#2) Address:

Company/Practice/Group Name

Address

City State Zip

Phone FAX

M T W Th F Sa Sn

EDUCATION:

High School_____ Location_____ Date of Graduation _____

Undergraduate College or University_____ Location _____

Dates attended_____Degree _____

Optometric College or University_____ Location _____

Date of Graduation_____ Residency: Yes or No Date of Completion: _____

Location of Residency: _____

Where did you hear about the Wisconsin Optometric Association? _____

_____

How can membership in WOA best serve your needs as an optometrist?_____

_____

LICENSE INFORMATION AND HISTORICAL DATA: OE Tracker #: _____

Wisconsin Registration Certificate #_____ Date of licensing by Wisconsin Board of Examiners: _____

DPA Certified? ___Yes ___No ___Pending TPA Certified ___Yes ___No ___Pending

Do you hold license from any other state:_____ Number of years in optometric practice outside of WI: ____

State(s) and date(s) of licensure _____

Are you or have you ever been a member of any other optometric association? ___Yes ___No (Check One)

Name(s) of association(s) and years of membership: _____

Has your optometric license or optometric association membership ever been revoked or suspended? _____

If yes, when and where _____

Other Information: The success of the profession of optometry relies heavily on effective public relations, personal relationships with legislators and volunteering of association members. Please complete the information below.

Do you have a personal connection with any Wisconsin State Senators or Representatives? ___Yes ___ No

If so who and what is the relationship: _____

Do you have any special connections with local newspapers, radio or television stations? ___Yes ___ No

If yes please explain: _____

Would you like to serve on a WOA committee? _____Yes _____Not at this time

Available Committees:
_____Advocacy/Legislative _____Education _____Membership _____Outreach/Communications

Referral Network: Please check the areas you specialize in or have extensive training or experience:

_____ Contact Lens – Regular
_____ Contact Lens – Specialty
_____ Glaucoma Management
_____ Developmental Vision/Vision Therapy
_____ Sports Vision
_____ Low Vision
_____ Geriatric Vision
_____ Surgery Co-Management
Types: _____
_____ Children's Vision
_____ Infant Vision

I hereby declare that these statements are true. I shall adhere to and abide by the Code of Ethics and the Bylaws of the Wisconsin Optometric Association and I will pay all dues and assessments as established within the bylaws.

Signed:_____