



North Dakota Society of Eye Physicians and Surgeons Membership Application

Personal Data

First name: _____ Middle Initial: _____ Last name: _____

Title (check all that apply): _____ MD _____ DO _____ Ph.D. _____ OD _____ Other: _____ Subspecialty

Date of Birth: _____ Email address: _____

Marital status: _____ M _____ S If married, spouse's name: _____

Home address: _____

Home phone: _____ Home fax: _____

Practice Data

Number of years in practice: _____

Type of practice: _____ solo _____ group _____ clinic _____ academic _____ other: _____

If group practice, how many ophthalmologists are in the group? _____

Office name: _____

Office address: _____

Office phone: _____ Fax: _____

Education

Medical school: _____ Graduation date: _____

Residency: _____ Completion date: _____

Fellowships: _____ Completion date: _____

ABO certified? _____ Yes _____ No (If no, are you eligible? _____ Yes _____ No)

Other certification? _____ Yes _____ No _____ Year certified / By whom _____

Membership Categories (check one) _____ Active \$500 _____ Inactive (retired) none

Mail completed application along with payment to: **NDSEPS
1622 East Interstate Ave
Bismarck, North Dakota 58503-0512**

Signature: _____ **Date:** _____