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:**_____