



Illinois Optometric Association

304 West Washington Street • Springfield, Illinois 62701
217-525-8012 • FAX 217-525-8018

APPLICATION FOR COLLEGIATE MEMBERSHIP IN THE ILLINOIS OPTOMETRIC ASSOCIATION

I hereby apply for collegiate membership in the Illinois Optometric Association

PLEASE PRINT CLEARLY:

_____ LAST NAME _____ FIRST NAME _____ MI _____

MAILING ADDRESS DURING SCHOOL YEAR (STREET, APARTMENT NUMBER)

_____ CITY _____ STATE _____ ZIP _____

EMAIL ADDRESS

NAME AND PERMANENT ADDRESS OF RELATIVE OR FRIEND
(BOTH ADDRESSES ARE REQUIRED FOR OUR RECORDS)

NAME OF RELATIVE OR FRIEND

STREET ADDRESS OF RELATIVE OR FRIEND

_____ CITY _____ STATE _____ ZIP _____

ALL MAIL SHOULD BE SENT TO:

MAILING ADDRESS ABOVE

PERMANENT ADDRESS ABOVE

DATE OF BIRTH: _____ / _____ / _____

SEX: _____ MALE _____ FEMALE _____

NAME OF ACCREDITED SCHOOL CURRENTLY ATTENDING AND MAILBOX NUMBER

EXPECTED GRADUATION DATE _____ MONTH _____ YEAR _____

1ST AND 2ND CHOICE OF STATES WHERE YOU ARE MOST LIKELY TO PRACTICE:

1. _____ 2. _____