LA EPS | LOUISIANA ACADEMY OF EYE PHYSICIANS AND SURGEONS

Personal Information

Full Name:	*Date Of Birth:*
Home Address (preferred address for mailing? _____):	
Email Address: *May other LAEPS members view this email address? (circle one) Yes No*	
Phone: | *_____ Male _____ Female* | *Spouse's Name: Not Married _____*	
LA License #:	

Business Information

Specialty within Ophthalmology:	
Type of Practice: _____ Solo _____ Same Specialty Group _____Multi-Specialty Group _____ Academic _____Other	
Primary Office / Practice / Institution Name:	
Others MDs in practice:	
Business Address (preferred address for mailing? _______):	
Office Phone:	*Office Fax:*
Practice Administrator:	
Practice Administrator Email:	

Medical Education

Medical Education: (School and Completion Date)
Residencies / Fellowships (Programs and Completion Date): *Currently in training: Yes No*

Payment Information

Dues *(circle):* ***$600:** Active* | ***$300:** 2nd year new-physician* | ***Free:** 1st year new-physician* | ***Free:** Retired Physician* | *Free: Member-In-Training*
Payment *(circle): Check enclosed Charge my: VISA MC AMEX DISC*

Credit Card Payment

Name on Card:	*Card Number:*
CVV2 Number (4-digits on front of AMEX or 3-digit on back of others):	*Expiration Date:*
Billing Address:	

By signing below, you certify that:

1. *The above information is true.*
2. *You are a duly licensed physician practicing Opthalmology in Louisiana.*

I hereby apply for membership in the LAEPS and agree to abide by its Constitution and Bylaws.

Signature:	*Date:*

***Please send application and payment to:** LAEPS, 6767 Perkins Road, Suite 100, Baton Rouge, LA 70808 or Fax 225-7685601*

Payment is required at the time of application