CALIFORNIA PARAOPTOMETRIC SECTION

INDIVIDUAL MEMBERSHIP

EDUCATION ▪ PROFESSIONALISM ▪ FELLOWSHIP

☐ **NEW** ☐ **RENEWAL**

APPLICANT INFORMATION

❑ Preferred Mailing Address

Name: _____
Last *First* *M.I.* *Certification (ABO/NCLE/CPOT/etc.)*

Home Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____ E-mail: _____

❑ *Yes! Please contact me. I am interested in becoming a CPS volunteer and would like to be involved in these areas:*

☐ *Career Development* ☐ *Membership*

☐ *Governance* ☐ *Education*

PRIMARY WORK LOCATION

❑ Preferred Mailing Address

Employed By (Doctor's Name/Company): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____

ADDITIONAL DATA (optional)

- Year started working as a Paraoptometric: _____ Date of Birth: _____ Gender: ❑ Male ❑ Female
- Employment Setting: ❑ Solo Practice ❑ Group/Partnership Practice ❑ Optical Chain ❑ Clinic ❑ Other (specify): _____
- Is your employer a California Optometric Association member? ❑ Yes ❑ No ❑ Don't know
- Is your employer supporting your membership in the California Paraoptometric Section? ❑ Yes ❑ No

MEMBERSHIP DUES

Membership Dues: $30 provides membership for one calendar year, January through December. It is not refundable or transferable. Please enclose a check payable to *California Paraoptometric Section* with your application.

I hereby apply for membership in the California Paraoptometric Section (CPS) of the California Optometric Association. If accepted, I will abide by its bylaws, support its objectives and pay the established annual dues. CPS policy states that member is vested in the individual Paraoptometric, it is not refundable or transferable.

Signature: _____ Date: _____

CALIFORNIA PARAOPTOMETRIC SECTION
2415 K Street Sacramento CA 95618 • Toll Free (800) 877-5738 / (916) 441-3990 • Fax (916) 448-1423

FOR CPS USE

App Rec'd	Dues: Check #	Member ID#