

NEW JERSEY PARAOPTOMETRIC SECTION MEMBERSHIP APPLICATION

DATE: _____

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP _____

PREFERRED MAILING ADDRESS: HOME BUSINESS

HOME/MOBILE PHONE _____ BUSINESS PHONE _____

EMAIL ADDRESS _____ FAX _____

SPONSORING OD: _____

1. NAME OF EMPLOYER(S) _____

2. HOW LONG HAVE YOU BEEN EMPLOYED AS A PARAOPTOMETRIC? _____

3. HOW WERE YOU TRAINED? ON THE JOB TECHNICAL SCHOOL HOME STUDY COURSE

4. PLEASE INDICATE THE AREAS IN WHICH YOU WORK IN THE OFFICE (CHECK ALL THAT APPLY)

- | | |
|---|---|
| <input type="checkbox"/> FRONT DESK | <input type="checkbox"/> CONTACT LENSES |
| <input type="checkbox"/> OFFICE MANAGEMENT | <input type="checkbox"/> VISION THERAPY |
| <input type="checkbox"/> FRAME STYLING | <input type="checkbox"/> LOW VISION |
| <input type="checkbox"/> DISPENSING | <input type="checkbox"/> LABORATORY |
| <input type="checkbox"/> CLINICAL TESTING (FIELDS, TONOMETRY, BLOOD PRESSURE) | |

5. ARE YOU A/AN: CPO CPOA CPOT NCLE ABO COMT COT

6. PLEASE INDICATE ANY TOPICS/LECTURES YOU WOULD LIKE PRESENTED AT FUTURE MEETINGS:

PLEASE SIGN BELOW TO INDICATE THAT YOU HAVE READ THE BYLAWS OF THE NEW JERSEY PARAOPTOMETRIC SECTION AND THAT YOU AGREE TO ABIDE BY THEM AS A MEMBER.

YOUR SIGNATURE

SPONSORING OD SIGNATURE

PLEASE RETURN APPLICATION(S) AND CHECK FOR \$40 (INDIVIDUAL) OR \$100 (OFFICE)
MADE PAYABLE TO NJSOP AND SEND TO:

NEW JERSEY SOCIETY OF OPTOMETRIC PHYSICIANS
C/O THE NEW JERSEY PARAOPTOMETRIC SECTION
4 AAA DRIVE, SUITE 204
HAMILTON, NJ 08691