

Membership Application

PERSONAL INFORMATION				DATE:
Status (please check in box)		☐ Full Time	☐ Part Time (Less than 75 days a year)	
Please print clearly.				
First Name (print above)	Initial	Last Name	ACO Registration Number	
Female ☐		Male ☐	Prefer not to say ☐	
Preferred name if different than above		Gender	Birth Date (MM/DD/YYYY)	
Home Address		City	Province	Postal Code
Home Phone Number		Cell Number		
Spouse First Name		Spouse Last Name		
Languages spoken other than English (please list all)				

PRACTICE INFORMATION			
Primary Office Location (Office #1 - Main)			
Practice Name			
Address		City	Province
			Postal Code
Phone Number		Fax Number	Website
This office is: ☐ Non-Dispensing ☐ Dispensing ☐ Participates in the Eye See . . . Eye Learn Program ☐ Eyesafe			

Satellite Office Location (Office #2)			
Practice Name			
Address		City	Province
			Postal Code
Phone Number		Fax Number	Website
This office is: ☐ Non-Dispensing ☐ Dispensing ☐ Participates in the Eye See . . . Eye Learn Program ☐ Eyesafe			

Satellite Office Location (Office #3)			
Practice Name			
Address	City	Province	Postal Code
Phone Number	Fax Number	Website	
This office is: ☐ Non-Dispensing ☐ Dispensing ☐ Participates in the Eye See . . . Eye Learn Program ☐ Eyesafe			

EDUCATION	
Optometric School	Year of Graduation
Degrees and Professional designations (eg. - F.A.A.O., MSc., etc.)	

YOUR SPECIALITY and SERVICES (please check all that apply)			
☐ Children's Vision/Developmental/Pediatrics	☐ Hospital/House/Nursing Home Visits	☐ Refractive Surgery/Pathology	
☐ Bailey-Lovie Testing	☐ Low Vision	☐ Visual Training/Therapy	
☐ Farnsworth Colour Test	☐ Orthokeratology	☐ Safety Eyewear	

MAILING INFORMATION
Where should AAO email be sent? (Note: Majority of AAO information is sent by email)
Email Address:

☐ I authorize the Alberta Association of Optometrists (AAO) to share my clinic information and email address with the Canadian Association of Optometrists (CAO).

ACKNOWLEDGEMENT
I hereby apply for a membership in the Alberta Association of Optometrists. I agree to abide by its By-Laws and will promptly advise the AAO of any changes in practice locations or membership status. I understand that membership in the AAO automatically grants membership in the Canadian Association of Optometrists. I also understand that by supplying my email address that I give the AAO permission to contact me via email, in accordance with the CASL legislation.
Optometrist Signature: _____ Date: _____

The information you have provided will be used by the AAO in its membership database. This information is important to the AAO and is kept confidential, except for your practice name(s), address(es), phone and fax number(s) and website address(es) that will be listed on the "Find An Optometrist" section of the AAO website. Your practice information may also be provided to members of the public requesting specific services.

It is very important to notify the AAO as soon as possible of any practice changes, so that we can update this information online.