Connecticut Society of Eye Physicians

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Membership Application

Fax to 860-567-3591 or Email debbieosborn36@yahoo.com

PERSONAL INFORMATION

First Name:______________________ Middle Initial _____ Last Name_______________________________

Title: (check all that apply) ____ MD ____ DO

Other: ____

Date of Birth: ____

Marital Status: ______M ______S If Married, Spouse's name:_________________________________

County of Residence: ____

Home Address: ____

Home Phone: _____________________________________ Home Fax:_________________________________

Email Address: ____

Where would you prefer receiving mail (check one) _____ home _____ primary office _____ satellite office

State Representative(s) and/or Senator(s) with whom you are acquainted:_______________________________

____

Please list your House District (if known): ____

Please list your Senate District (if known): ____

PRACTICE INFORMATION

Number of years in practice:____

Type of practice: ____

Primary office address: ____

Primary Office phone:____

Days in primary office (check all that apply) ____M ____T ____W ____Th ____F ____S

Satellite Office address: ____

Sattelite office phone: ____

Days in satellite office (check all that apply) ____M ____T ____W ____Th ____F ____S

Sub-specialty: ____

Positions held (after medical school, not including training): ________________________________

____

HOSPITAL INFORMATION

Hospital for which privileges are held: ______________________________

____

How many years have you been on the staff: ______________________________

Have you ever been denied privileges at any hospital? _____ If yes. please state the reason: ______________

____

Do you have a valid CT license? _____ License number: ______________________________

Has your license ever been revoked or suspended? ______ If yes, please give explanation: ______________

____

EDUCATION INFORMATION

College: ______________________________ Grad date: ______________

Medical School: ______________________________ Grad date: ______________

Residency: ______________________________ Completion date: ______________

Fellowships: ______________________________ Completion date: ______________

ABO certified? ______ Yes ______ No If no, are you eligible? ______ Yes ______ No

Other certification? ______ Yes ______ No By whom? ______________________________

Year Certified ______________ Please attach a copy of this certification.

Medical License number: ______________ State Issued: ____________ Exp. Date: __________

Please list your scientific articles and other publications (attach additional sheets if necessary):

____

____

____

____

PROFESSIONAL/HONORARY AFFILIATIONS

Military service (dates and branch): ______________________________

Hospital and University affiliations: ______________________________

Other medical society memberships: ______________________________

MEMBERSHIP CATEGORIES

_____ 1st Year in Practice $375.00

_____ Part-time ophthalmologists $375.00

_____ Full Membership $750.00

I hereby submit my application for membership in the CSEP. This completed Membership Application includes my professional qualifications.

Signature: ______________________________ Date: ______________