

## MEMBERSHIP APPLICATION

*Resident/Fellow membership is offered to physicians who are currently completing their training. A letter from the program chair/director must accompany this application.*

**Membership Category** (*Check one*):       Resident (*no fee*)     Fellow (*no fee*)

Name of Applicant \_\_\_\_\_  
Business Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Business Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_ E-mail \_\_\_\_\_  
Office Contact Person \_\_\_\_\_

M.D. (D.O.) Degree \_\_\_\_\_ University \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date Degree Awarded \_\_\_\_\_

Residency \_\_\_\_\_  
Date to be completed \_\_\_\_\_

Post Graduate Training \_\_\_\_\_  
Date to be completed \_\_\_\_\_

Board Certified     Board Eligible  
Subspecialty Interest:  Cataract     Cornea     Glaucoma     Refractive     Retina

*Please make check payable to:*    **American College of Eye Surgeons**  
334 East Lake Road, #135, Palm Harbor, FL 34685-2427  
Tel: 727.480.8542; Fax: 727.786.6622

**For ACES Administration Only**

Date Received \_\_\_\_\_ Check \_\_\_\_\_ Amount \_\_\_\_\_

Date Reviewed \_\_\_\_\_ Date Accepted (not accepted) \_\_\_\_\_ By: \_\_\_\_\_

Date Applicant Notified \_\_\_\_\_