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Kansas Society of Eye Physicians & Surgeons

Administrative Office: 10 W. Phillip Rd., Suite 120 ■ Vernon Hills, IL 60061
Phone: 800/838-3627 ■ *Fax:* 847/680-1682
E-mail: Rich@KansasEyeMD.org ■ *Web:* www.KansasEyeMD.org

Membership Application

Please provide the information requested below and return with the your dues payment to:
Kansas Society of Eye Physicians & Surgeons, Administrative Office, 10 W. Phillip Rd., Suite 120, Vernon Hills, IL 60061-1730
By fax: 847/680-1682 By email: Rich@KansasEyeMD.org

**** * * Please complete BOTH pages of application and the payment sheet. * * ****

Membership Categories (check one):

☐ Active/full - $800	Physicians actively engaged in full-time practice of ophthalmology who have a valid Kansas medical license.
☐ Associate/new in practice - $250	Physicians in their first three years of practice in ophthalmology who have a valid Kansas medical license. CHECK ONE: ☐ 1st year ☐ 2nd year ☐ 3rd year
☐ Associate/academic - $250	Physicians actively engaged full-time on the ophthalmology faculty at an accredited medical school and who have a valid Kansas medical license.
☐ Associate/out-of-state - $250	Physicians who reside or practice ophthalmology in another state, who are members of their home-state ophthalmology society, and who have a valid Kansas medical license.
☐ Associate/part-time - $250	Physicians who practice ophthalmology part-time or are semi-retired and who have a valid Kansas medical license.

Note - Residents & fellows in training are automatically enrolled as KSEPS members; no dues are owed.

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Applicant's name ***enter here*** ➜	
Degree(s) - ***check all that apply***	☐ MD ☐ DO ☐ PhD ☐ Other _____
PRACTICE INFORMATION	
Practice Name	
Office Mailing address *Street & Suite*	
City/State/Zip	
Office phone	
Office fax	
HOME INFORMATION *(will not be published)*	
Street	
City/State/Zip	
Home phone	
Preferred E-mail	
Communication Preferences *(check one of each category)*	*Mailing address*: ☐ Office ☐ Home *Contact preference:* ☐ Email ☐ Regular mail

1.22.2020

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For Office Use Only

Date received:
Dues amount paid:
Date approved:

BACKGROUND INFORMATION
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Kansas medical license number	
Board certification & date	
Education (Undergraduate/Graduate) List School(s), Degree(s) and Year(s)	
Medical school & year graduated	
Ophthalmology residency program(s) Location Dates (years)	
Fellowship(s) completed Subspeciality Location Dates	
Academic Appointments School(s) Position(s)	
If your practice primarily is a subspecialty, please indicate (check only <u>one</u>)	☐ I primarily practice comprehensive ophthalmology ☐ Cornea/external disease ☐ Glaucoma ☐ Neuro-ophthalmology ☐ Ophthalmic pathology ☐ Pediatric ophthalmology ☐ Plastic & reconstructive surgery ☐ Retina/vitreous ☐ Uveitis ☐ Other: _____

If you have any comments or wish to provide any additional information, please enter here:

Complete your application by filling in your payment information on the next page . . .

KSEPS- Application Payment Information

Applicant's name: _____

Amount enclosed: $_____

Form of payment: ☐ Check* ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Make checks payable to "Kansas Society of Eye Physicians & Surgeons"

Credit Card # | | | | | | | | | | | | | | | | Exp. Date | | | / | |

Security Code (3 or 4 digits) | | | |

Name on card: _____

Signature _____

Credit card billing address (if different from above): _____

Billing address city/state/zip: _____