KANSAS OPTOMETRIC ASSOCIATION

# Application for Student/Military Membership

**Please indicate the type of membership requested:**

☐ Student/Resident ($10/year) ☐ Military ($10/year)

**Please Print or Type**

Name _____
First Middle Last Nickname

College of Optometry/Military Base _____

Place of Birth _____

Date of Birth _____ Date of Anticipated Graduation _____

**Current Contact Information:**

Street Address _____ E-Mail _____

City _____ State _____ Zip _____

Telephone _____ Mobile _____

**Permanent Contact Information:**

Street Address _____ Telephone _____

City _____ State _____ Zip _____

Signed: _____ Date: _____

**Please complete and return the application form, along with proof of your AOA student membership and payment to:**

Kansas Optometric Association
1266 SW Topeka Boulevard
Topeka, KS 66612
(785) 232-0225
(785) 232-6151 (FAX)
info@kansasoptometric.org

Please charge $ _____ to my: ☐ VISA ☐ MasterCard

Card Number _____ Expiration Date _____

Name (Please print) _____ Signature _____