

**Please Print Clearly and  
Review all information**

Missouri License # \_\_\_\_\_

OE Tracker # \_\_\_\_\_

Name \_\_\_\_\_

Email \_\_\_\_\_

Address \_\_\_\_\_

State Rep/District \_\_\_\_\_

\_\_\_\_\_

State Senator/District \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Cell: \_\_\_\_\_

**SLOS MEMBERSHIP DUES June 1, 2018 through May 31, 2019**

_____ Full Member	<u><i>I am a member of the MOA &amp; the AOA</i></u> If paying by credit card, pay \$78.75.	\$75.00
_____ University Class	Full time educator at a College of Optometry and member of the State Assn. & the AOA If paying by credit card, pay \$52.75	\$50.00
_____ Retired Member	I am practicing less than 4 hours per week. If paying by credit card, pay \$27.25	\$25.00
_____ New Graduate	Graduated May, 2018 from a College of Optometry If paying by credit card, pay \$27.25	\$25.00
_____ Associate Member	<u><i>All other optometrists not members of MOA/AOA</i></u> If paying by credit card, pay \$182.75	\$175.00

**NOTE: 15% of all annual dues is not deductible as that percentage can be allocated to legislative and/or lobbying efforts in the State of Missouri**

I am associated with: \_\_\_\_\_

Other professional memberships: AOA MOA IOA AAO HOACLS Other \_\_\_\_\_

I wish to be contacted by: Postal Mail \_\_\_\_\_ Email Only \_\_\_\_\_ Both \_\_\_\_\_

I understand that due to new regulations, meeting Sponsors require a copy of the CE sign in sheet, however;

*I do not want my information shared with other entities* \_\_\_\_\_

*You may share my information with other entities approved by the SLOS Board* \_\_\_\_\_

I would volunteer for: Screenings \_\_\_\_\_ Health Fairs \_\_\_\_\_ Public speaking \_\_\_\_\_

I am paying by credit card: Card # \_\_\_\_\_ Expiration \_\_\_\_\_

Name on card \_\_\_\_\_ Billing Zip Code \_\_\_\_\_ CV Code \_\_\_\_\_

Mail completed form with payment to: SLOS, P. O. Box 6136 / Chesterfield, MO 63006-6136