

**VIRGINIA SOCIETY OF OPHTHALMIC MEDICAL PERSONNEL
MEMBERSHIP APPLICATION**

NAME: _____

CERTIFICATIONS: _____

CERTIFYING AGENCY _____ **HOME**

ADDRESS: _____

_____ **ZIP**

CODE: _____

TELEPHONE _____ **HOME** _____ **OFFICE**

FAX: _____ **EMAIL** _____

PRACTICE NAME: _____

Which category best describes your major professional activity?

_____ **Ophthalmic Assistant** _____ **Registered Nurse** _____ **Ophthalmic
Technician** _____ **Practical Nurse** _____ **Ophthalmic Technologist** _____
Orthoptist _____ **Ophthalmic Photographer** _____ **Ocularist** _____
Contact Lens Technician _____ **Optician** _____ **Office Manager** _____
Optometrist _____ **Receptionist** _____ **Secretary** _____ **Billing Clerk**
_____ **Other**

VSOMP dues are \$50.00 per member per calendar year.

Please enclose a \$50.00 check made out to VSOMP.

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