

# APCLAO

ASIA PACIFIC CONTACT LENS ASSOCIATION  
OF OPHTHALMOLOGISTS

## **MEMBERSHIP APPLICATION FORM**

### **Personal Data**

Please type or print *clearly*.

LAST NAME : \_\_\_\_\_

FIRST NAME : \_\_\_\_\_

### **Preferred mailing address for all correspondence.**

This is  office address  home address (**IMPORTANT:** please check one)

Practice Name (if applicable) : \_\_\_\_\_

Street Address : \_\_\_\_\_

\_\_\_\_\_

City : \_\_\_\_\_ State/Province : \_\_\_\_\_

Country : \_\_\_\_\_ Postal Code : \_\_\_\_\_

Telephone No : \_\_\_\_\_ Fax No : \_\_\_\_\_  
Please include country/city code Please include country/city code

Primary Email address : \_\_\_\_\_

Secondary Email address : \_\_\_\_\_

Date of Birth : \_\_\_\_\_  Male  Female  
DD MM YYYY

### **Medical Training** Complete all information pertaining to your medical training, licensing, and certification.

Name of Medical School : \_\_\_\_\_

Degree(s) : \_\_\_\_\_ Month/Year : \_\_\_\_\_  
(e.g. MD, DO, MBBS) MM/YY

**Training in Ophthalmology (Required – Please attached certificate.)**

Ophthalmic Training : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Hospital Affiliations**

1. \_\_\_\_\_ Position : \_\_\_\_\_  
2. \_\_\_\_\_ Position : \_\_\_\_\_  
3. \_\_\_\_\_ Position : \_\_\_\_\_  
4. \_\_\_\_\_ Position : \_\_\_\_\_

**References:**

1. \_\_\_\_\_  
2. \_\_\_\_\_

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Please return your completed application together with your CV to:

APCLAO Secretariat  
c/o Singapore National Eye Centre  
11 Third Hospital Avenue  
Singapore 168751

Email: APCLAO@sneec.com.sg

Or

Fax your completed application to +65-6226 3395

We will advice you on the membership payment once we received your application.