



Membership Application

Please fill in the information below and send this application, along with a copy of your Society's Articles of Incorporation, Statutes, Constitution or Bylaws, to:

International Council of Ophthalmology
Attn: Dr. Ivo Kocur
Rue de Lyon 77
CH-1203 Geneva
Switzerland
Email: icomembership@icoph.org

Please type or print clearly. Thank you for your interest in joining the ICO.

1. Name of the Society:

2. Nature and Focus of the Society:

Is your Society primarily?

National (focused mainly within one country)

International or supranational (focused on many countries, e.g., European)

Do you have a substantial international membership (i.e., members from various countries)?

Yes No

Do you offer regular meetings that attract participants from many countries?

Yes No If so, how often:

Is your society a not-for-profit organization with a governing board that meets periodically?

Yes No

Do you have regular, periodic election of officers by members?

Yes No If so, how often:

Do you have Articles of Incorporation, Statutes, Bylaws, Rules or Regulations that govern how you operate?

Yes No *(If yes, please send with your application.)*

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If your society is focused on a single subspecialty or special interest, please select the appropriate category or categories:

- | | |
|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| <input type="checkbox"/> Cataract and Lens | <input type="checkbox"/> Optics, Refraction and Contact Lens |
| <input type="checkbox"/> Cornea and External Disease | <input type="checkbox"/> Pediatric Ophthalmology, Strabismus and Genetics |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Refractive Surgery |
| <input type="checkbox"/> Low Vision and Visual Rehabilitation | <input type="checkbox"/> Retina and Vitreous |
| <input type="checkbox"/> Neuro-ophthalmology | <input type="checkbox"/> Uveitis and Immunology |
| <input type="checkbox"/> Ophthalmic Pathology and Oncology | <input type="checkbox"/> Preservation of Vision/Prevention of Blindness |
| <input type="checkbox"/> Ophthalmic Plastic and Reconstructive Surgery, Orbit and Adnexae | <input type="checkbox"/> Other (e.g., research, education)
Please specify: |

Number of members:

Annual dues charged per member:

Annual budget:

3. Society Address

Address:

City:

State, province or district:

Postal Code:

Nation:

Telephone (include city and country codes):

Alternative telephone (include city and country codes):

Fax (include city and country codes):

Email address:

Web site:

4. Society Leadership

President:

Email address:

Treasurer:

Email address:

Secretary General, Chief Executive or Administrator (name and title):

Email address:

5. Signature, Date and Contact Person

Signature:

Name (please print):

Date:

Person to contact regarding ICO membership application:

Email address:

Telephone: