SUBSPECIALTY SOCIETY MEMBERSHIP APPLICATION FORM

I. Organization Particulars

Name of Society: ________________________________________

Office Address: ________________________________________

Secretariat Location: ______________________ Website: ______________________

President: ______________________ Email: ______________________

Secretary-General: ______________________ Email: ______________________

Treasurer: ______________________ Email: ______________________

Number of Members: ________________________________________

Number of International Members: ________________________________________

Number of Ophthalmologists: ________________________________________

Contact Person Information:

Family Name: ______________________ First Name: ______________________

Position: ______________________

Tel No.: ______________________ Fax No.: ______________________

Email: ______________________

II. Criteria for Subspecialty Society Membership *

☐ The applicant is a major subspecialty society in the Asia-Pacific region recognized as of good standing with proper society/company registration;
   (Please attach a copy of the official Registration Certificate AND the Constitution OR Memorandum and Articles, whichever is applicable.)

☐ The applicant consists of at least 5 Council Members representing at least 5 member nations and/or territories of the APAO;

☐ The applicant has a proper process to elect and/or appoint Council Members/Office Bearers.
   (Please also attach the By-Laws if the election/appointment process is not listed in the Constitution or Memorandum and Articles.)

III. Major Activities

☐ Academic Meeting
   Please specify: ________________________________________

☐ Certifying and qualifying examinations

☐ Training Courses for Specialists

☐ Research and Investigation of Eye Diseases

☐ Publications
   Please specify: ________________________________________

☐ Prevention of Blindness Campaigns

☐ Others
   Please specify: ________________________________________
IV. Nomination of a Representative in the APAO Council†

Family Name: __________________________ First Name: __________________________

Title: Prof. / Dr. Nationality: __________________________

Professional Qualification(s): __________________________

Position: __________________________

Address: __________________________

Tel No.: __________________________ Fax No.: __________________________

Email: __________________________

We understand the APAO council has the final decision in the approval of this application. We also agree to abide by the Memorandum and Articles and By-laws of the Asia-Pacific Academy of Ophthalmology upon acceptance of our application by the APAO Council.

Signature: __________________________ Date: __________________________

(Position) __________________________

* An annual membership fee will be collected on a biennially basis upon successful application.

† Upon successful application, the recommended representative will serve as Councilor of the APAO starting after the APAO Tokyo congress 2014 for a remaining term of 3 years. To change your representative in the APAO Council, please write to the APAO Central Secretariat at least 2 weeks before the next Council Meeting.