

**AMERICAN UVEITIS SOCIETY
MEMBERSHIP APPLICATION FORM**

Date _____

Name: _____

Professional Address: _____

Contact Information:

Office: (____) _____

Home: (____) _____

Fax: (____) _____

Email: _____

EDUCATION

Medical School: _____ Year Graduated: _____ Degree: _____

Graduate School: _____ Year Graduated: _____ Degree: _____

Internship: _____ Year Completed: _____

Residency: _____ Year Completed: _____

Postdoctoral Training:

Type & Preceptor:

Place: _____ Dates: _____

Additional Training:

Type & Preceptor:

Place: _____ Dates: _____

CURRENT PRACTICE OR RESEARCH POSITION

Place: _____

Rank/Position: _____ Year Started: _____

**AMERICAN UVEITIS SOCIETY
MEMBERSHIP APPLICATION FORM (CONT'D)**

PRACTICE/RESEARCH/TEACHING DEVOTED TO UVEITIS

1. How many years since completing training in uveitis or ocular immunology? _____
2. Estimate percentage of time devoted to management of patients with uveitis, research in ocular immunology, or teaching in uveitis or ocular immunology. _____%

AMERICAN ACADEMY OF OPHTHALMOLOGY

Are you a Member or Fellow of the AAO? No Yes
If no, are you planning on becoming a member of the AAO over the next year? No Yes

**BRIEF DESCRIPTION OF CURRENT INTERESTS IN OCULAR INFLAMMATION
(please completed this section- please do not write 'refer to CV')**

Clinical Research:

Basic Science Research:

PUBLICATIONS (Please attach updated copy of CV and bibliography)

List (or refer to # on bibliography) at least 2 publications primarily on uveitis or ocular inflammatory disease in refereed journals within last 4 years on which you were 1st or 2nd author).

- 1.
- 2.

LETTERS OF RECOMMENDATION

You must submit two letters of recommendation, from two individuals, **at least one of whom must be a current member of the American Uveitis Society**. Please submit these letters WITH your application form. Please indicate the names and AUS membership status of each reference below:

1. _____ AUS member: No Yes
2. _____ AUS member: No Yes

Send completed application and all correspondence to:

Janet L. Davis, MD
900 N.W. 17th Street
Miami, FL 33136
TEL: 305-326-6377
FAX: 305-326-6071