



APPLICATION FOR FULL MEMBERSHIP International Strabismological Association

According to the By-Laws of the International Strabismological Association (I.S.A.) "any physician who has a special interest in strabismology shall become a member on application to the Secretary provided that he or she is duly proposed and seconded by two members of the I.S.A."

Herewith, I am sending you the dues **to the account of the INTERNATIONAL STRABISMOLOGICAL ASSOCIATION.**

FAMILY NAME: _____ **FIRST:** _____ **MIDDLE:** _____

Academic position, subspecialty: _____

POSTAL MAILING ADDRESS:

Street/Avenue: _____

City: _____ State/Province: _____

ZIP (Postal Code): _____ Country: _____

Phone: _____ FAX: _____

E-Mail Address: _____

Name and Country of I.S.A. Members who propose and second my application:

Name _____ Country _____

1. Japanese Association of Strabismus and Amblyopia (JASA) JAPAN

2.

As soon as these requirements are fulfilled, I shall be a full member and as such receive Newsletters, Membership Roster, By-Laws and invitations to the meetings of the Association:

orthoptist

Signature: _____

Name printed exactly as it should appear on the ISA membership certificate:

Dues Payment: \$125.00 USD / 2010-2013 (reduced over 25% from annual price!)

[] Check enclosed

[] Charge my annual dues to my credit card as indicated below:

() Mastercard () VISA () Discover () American Express

[] Paid online

Account # _____ Exp. Date _____

Credit Card Billing Address _____
(if different from above)

Signature _____

This form and the annual fee should be sent to: Derek T. Sprunger, M.D., Section of Pediatric Ophthalmology, Indiana University School of Medicine, 702 Rotary Circle, Indianapolis, Indiana 46202-5175, USA. Fax: 317-328-8864 Email: isa.lms@juno.com

(Downloaded from JASA Web site)

(Rev. 9/10)