



**Membership Application Form**  
(For Individuals Only)

**Personal Information**

Last Name:	
First Name:	
Title: Prof. <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/>	Nationality:
Address:	
Phone Number:	Mobile Number:
Email:	

**Specialty Information**

Academic Background [Degree(s)]:
Professional Qualification(s):
Position:
Affiliation (Institute/Hospital/Company):
Experience in Ophthalmology and/or Tele-Ophthalmology:

**Category**

Regional member ( ) Associate member ( )

**Declaration**

By applying for membership with the Asia Pacific Tele-Ophthalmology Society, I hereby agree to abide by the Society's Constitution and By-laws upon successful application.

**Signature:**

**Date:**