



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

**Institute Information**

Name of Institution:		
Date of Establishment:		
Country:		
Office Address:		
Phone Number:		
Website:		
Person-in-charge:		
	Position:	Email:
Contact person:		
Name:	Position:	Email:

**Specialty Information**

Institutional Type:		
Hospital	Clinic	University
Research Institute	Tele-Medicine Management Company	Tele-Medicine Technology Company
Society	Association	Community Service Organization
What services does your institution provide? Please specify the scope of work.		
Briefly state your experience in ophthalmology and/or tele-ophthalmology:		

**Category**

Full institutional member ( ) Associate institutional member ( )

**Declaration**

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

**Signature:**

**Date:**