Partial Practice REQUEST FORM

4404 SE King Road, Milwaukie, OR 97222-5282
(503) 654-5036, FAX (503) 659-4189
execstaff@oregonoptometry.org

To The Executive Director Date: _____

I do hereby submit application for **request** of partial practice membership status, and submit the following information.

Name:_____

Home Address: _____

Phone: _____ E-Mail _____

Clinic Name: _____

Work Address: _____

Phone: _____ Fax: _____

Employment:: self-employed ☐ full time ☐ part time ☐

Please provide an explanation why you feel you might qualify for special practice status, and indicate how many hours per week on the average you are working. Note, status changes may be made in the first quarter of year only.

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Applicant's Signature: _____

OOPA/AOA dues are not deductible as charitable contributions for Federal Income Tax purposes. However, they may be deductible under other provisions of the Internal Revenue Code as a normal operating business expense of your practice.

_____

OOPA INTERNAL USE

Applicant Accepted_____ Rejected_____ Entered in the minutes of _____