



2011-2012 (2-YEAR) Membership Application/Renewal Form

Please Type or Print Clearly

Name: (First, M.I., Last)

Highest Degree: _____

Department: _____

Institution: _____

Street Address: _____

City, State, Zip, Country _____

Telephone: * _____

FAX: * _____

E-Mail Address: _____

* international dialing codes required if outside US

Field of Interest: Number top 3 preferences (e.g. 1. Glaucoma; 2. Drug delivery; 3. Receptors)

- | | | |
|--|--|---|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Clinical R&D |
| <input type="checkbox"/> Anti-glaucoma drugs | <input type="checkbox"/> Anti-angiogenic drugs | <input type="checkbox"/> Pharmacokinetics |
| <input type="checkbox"/> Aqueous humor dynamics | <input type="checkbox"/> Diabetic retinopathy | <input type="checkbox"/> Toxicology |
| <input type="checkbox"/> Neuroprotection | <input type="checkbox"/> Macular edema | <input type="checkbox"/> Drug delivery |
| <input type="checkbox"/> Neuropharmacology | <input type="checkbox"/> Anti-diabetic drugs | <input type="checkbox"/> Drug design |
| <input type="checkbox"/> Biochemical & cellular pharmacology | <input type="checkbox"/> Other retinal diseases | <input type="checkbox"/> Medicinal Chemistry |
| <input type="checkbox"/> Molecular biology and genetics | <input type="checkbox"/> Inflammatory diseases | <input type="checkbox"/> Analytical instrumentation |
| <input type="checkbox"/> Gene transfer | <input type="checkbox"/> Anti-inflammatory drugs | <input type="checkbox"/> Psychophysics |
| <input type="checkbox"/> Stem cells | <input type="checkbox"/> Immunopharmacology | <input type="checkbox"/> Imaging technologies |
| <input type="checkbox"/> Receptors | <input type="checkbox"/> Dry Eye | <input type="checkbox"/> Others (<i>specify</i>) |

I am a (please specify): New Renewing member (Member ID: _____)

<u>Membership Category</u>	<u>2 year membership 2011-2012 Fees*</u>
<input type="checkbox"/> Regular Member**	\$ 350.00
<input type="checkbox"/> Associate Member (Pre/Postdoctoral students, Fellows)	\$ 30.00
<input type="checkbox"/> Contributing Member (Corporation, Sponsor)	\$ 2,000.00
Membership Fee Total:	\$

* 2-year membership period: January 1, 2011 through December 31, 2012. Rates are in US dollars.

** Regular Members: indicate journal subscription preference online print no subscription needed

Payment Options

1. **Credit Card** Visa MasterCard/Eurocard

Card number: _____ Exp. Date: _____

Card Holder Name: (Please Print Clearly) _____

CC Billing Address (if different from above) _____

Card Holder Signature: (Required) _____

2. **Check**

Please enclose a check or money order in **US Dollar funds** drawn on a US Bank only, made payable to: **AOPT**

Please mail this form along with a check or credit card information to the Treasurer of AOPT: **Marsha McLaughlin, Alcon Research, Ltd., Mail Code R9-11, 6201 South Freeway, Fort Worth, TX, 76134, USA.** The regular membership dues include a 2-year subscription to *The Journal of Ocular Pharmacology and Therapeutics*. Associate members do not receive copies of JOPT. AOPT's U.S. Federal Tax Identification Number is: 38-3169020.