Kentucky Academy of Eye Physicians & Surgeons
P.O. Box 920, Pewee Valley, KY 40056
Phone: 1-859-300-2213
Email: Liz@kyeyemds.org

Last Name:_______________________________M.D., D.O. **First:**___________________________ **Middle:**_____________

Practice Name:____

Office Address;____ Suite: ________________________________

City;______________________________________ State:________________________ Zip:_____________________________

Office Telephone: __________________

Office Administrator:___________________________________ Office Administrator Email:______________________________

KAEPS communicates with its members via email. Please make sure we have a unique email address for you.

e-mail:____ @ ______________________ . _________________________

_____Comprehensive Ophthalmology _____Glaucoma _____Oculo-Plastics _____Pediatrics
_____Cornea/External Disease _____Anterior Segment Surgery _____Retina/Vitreous _____Neuro

Home Address:___________________________________ City:___________________________ State:___________ Zip:_______

Home Tel: (___)______ - _____________ Cell Phone: (____)_______ - ____________Date of Birth:________________________

KAEPS 2022 Membership Dues:

Active Dues
1st Year out of Training -------------- $100.00
2nd Year out of Training ------------ $275.00
3rd Year & thereafter ---------------- $550.00
Part-time------------------------------ $275

Out-of-State -------------- $100
Life Member or Retired - $0
Military ------------------- *Waived* if on active duty

Contributions or gifts to the KAEPS are not tax deductible as charitable contributions for federal income tax purposes. However, dues payments (except for specific governmental affairs expenses) may be deducted as professional or business expenses, to the extent allowable by law. 28 percent of these dues is non-deductible as it relates to a governmental affairs expense.

Payment

CHECK ENCLOSED FOR $___________________________ CHECK NO. ___________________________

CREDIT CARD PAYMENT. You may fill out this form or pay via our PayPal account at **paypal.me/kyeyemds.**

CREDIT CARD NUMBER: ____

EXPIRATION DATE:_____________________ SECURITY CODE:___________________AMOUNT AUTHORIZED $_________________

NAME ON CARD:____

ADDRESS OF CARDHOLDER____

CITY_______________________________________ STATE_______________ ZIP_____________+______________________

SIGNATURE OF CARDHOLDER_______________________________________ TEL. NO. FOR CONTACT (___)_________________

Please return a copy of this entire completed Membership Application with your check or this completed credit card authorization to:

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P.O. Box 920
Pewee Valley, KY 40056
Liz@kyeyemds.org