

OPHTHALMOLOGY

(Addendum To Application for Physicians and Surgeons)

1. Is your practice strictly office based? YES NO

2. Do you perform the following procedures:

a. Laser treatments? YES NO (number/month) _____

b. Radial Keratotomy? YES NO (number/month) _____

If "Yes", please specify type(s) of procedures performed: _____

3. Do you perform any cosmetic procedures? YES NO

Signature

Please Print Name