

Kentucky Optometric Association 2010 Partner Member Registration

Company Name: _____

Contact Name: _____ Title: _____

Phone: _____ FAX: _____

Email: _____ Website: _____

Address: _____

City: _____ State: _____ Zip: _____

Name(s) of Local Sales Reps: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Cell: _____

****Please turnover to list other Sales Reps.*

I would like to become a KOA Visionary Member for \$15,000.00 annually

I would like to become a KOA Gold Member for \$10,000.00 annually

I would like to become a KOA Silver Member for \$5,000.00 annually

I would like to become a KOA Bronze Member for \$2,500.00 annually

I would like to set up a time to discuss the possibility of becoming a Partner Member

Payment Method Check Master Card Visa Discover

Credit Card Number _____ Expiration Date _____

Name Printed on Card _____ Signature _____

**Return with remittance payable to:
Kentucky Optometric Association
P.O. Box 572, Frankfort, KY 40602
FAX: (502) 875-3782**

**For additional information
Phone: (502) 875-3516
Email: sarah@kyeyes.org**

Partner Member Sales Representatives Information cont.

Name(s) of Local Sales Reps: _____

Address _____

City _____ State _____ Zip _____

Email: _____ Cell: _____

Name(s) of Local Sales Reps: _____

Address _____

City _____ State _____ Zip _____

Email: _____ Cell: _____

Name(s) of Local Sales Reps: _____

Address _____

City _____ State _____ Zip _____

Email: _____ Cell: _____