STATE UNIVERSITY OF NEW YORK
SUNY STATE COLLEGE OF OPTOMETRY
NYSOA SCHOLARSHIP
APPLICATION FORM

Name ____
last first middle

Class Year ______________________________

E-Mail Address _____________________ Phone # __________________

After graduation do you intend to practice in New York State:
___Yes ___No

After graduation do you intend to remain a member of the AOA/NYSOA:
___Yes ___No

Please list your involvements in professional organizations (on campus, state-wide, nationally) while at SUNY State College of Optometry:

____
____
____
____
____
____
____
____

_______________________________ _____________________
Signature Date