

VOSH-Virginia

Volunteer Optometric Services to Humanity

Membership Application

I would like to join VOSH-Virginia's effort to facilitate the provision of vision care to people who can neither afford nor obtain such care.

I understand that any participation in a VOSH mission is at my own risk.

NAME: _____

ADDRESS: _____

OCCUPATION: _____

PHONE: _____ WORK PHONE: _____

EMAIL: _____

Please indicate if you are interested in participating in domestic or international VOSH-Virginia clinics or events _____

Please send this form with the correct amount for annual dues of \$45 Individual.
(\$65 family)

Dr. Suzanne Matriccino, OD
1450 Sachem Place, Suite 202
Charlottesville, Virginia 22901

