eyecareAmerica®
The Foundation of the American Academy of Ophthalmology

Volunteer Enrollment Form

Fax Back to: 415-561-8567
Or mail to: EyeCare America
PO Box 429098
SF, CA 94142-9098

Ophthalmologists are encouraged to volunteer for ALL of the following, please check all that apply.

A) ☐ I volunteer to provide a comprehensive, medical eye exam to ECA referred seniors (65 or older) and care for up to one year for any disease diagnosed during the initial exam—**at no out-of-pocket cost to ECA patients.** I will accept Medicare and/or other insurance reimbursement as payment in full; waiving co-payments and/or unmet deductibles as provided for by ECA's waiver issued by the HHS Office of the Inspector General. ECA patients without insurance receive care at no charge. I agree to contact ECA if I find a patient needs to see a subspecialist or care I am unable to provide.

B) ☐ I volunteer to provide a glaucoma eye exam and initiate treatment, if deemed necessary, to ECA referred patients (of any age) who are determined to be at increased risk for glaucoma. Patients with insurance will be billed and are responsible for any co-payments. Patients without insurance receive this care at no charge.

C) ☐ I volunteer to provide care for ECA re-referred patients who need to receive retinal care unable to be provided by the original referred doctor. Patient care is the same as the above care for seniors. I will accept Medicare and/or other insurance reimbursement as payment in full; uninsured patients receive care at no charge.

ECA volunteers agree to see no more than 15 ECA patients per fiscal year (4/1 – 3/31) for each of the above selections.

Signed: _____ Date: _____

Print Name Clearly: _____ AAO Member ID# _____

My signature indicates that I have read and agree to the conditions of participation outlined above.

I volunteer to provide care at the following practice location(s).

First office location:

Business Name _____

Number/Street _____

City: _____ State: ____ Zip Code: _____ Contact Person : _____

Phone: (_____)_____ Fax: (____)_____ Office e-mail: _____

Languages Spoken: _____

2nd office location:

Business Name _____

Number/Street _____

City: _____ State: ____ Zip Code: _____ Contact Person : _____

Phone: (_____)_____ Fax: (____)_____ Office e-mail: _____

Please add any additional offices on the backside or call our toll-free staff line 877-887-6327