

APPLICATION FOR CONTINUING EDUCATION GRANT

**Please Print:**

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_

EMPLOYMENT (if applicable)

Clinic/Practice Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Start Date\* \_\_\_\_\_

Position \_\_\_\_\_ Supervisor \_\_\_\_\_

*\*If you have been in your present position less than five years, please give details of previous employment on a separate sheet.*

Special Interests related to ophthalmology: \_\_\_\_\_

*I attest that all information provided in this application is true and accurate to the best of my knowledge, and that I have not received financial support, other than a Certification Grant from the JCAHPO Education and Research Foundation in the past two (2) years; please see guidelines for specific years that are eligible. (PLEASE NOTE: This includes ATPO and Stein Scientific Paper).*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Your essay and signed release form must accompany this application.**

Please mail to: JCAHPO Education & Research Foundation, 2025 Woodlane Drive, St. Paul, MN 55125-2998  
**Postmark deadline date: July 23, 2012**

***Faxes are not accepted***

For Foundation Use Only:

Fund: \_\_\_\_\_ Amount: \_\_\_\_\_ Approved: \_\_\_\_\_

Fund: \_\_\_\_\_ Amount: \_\_\_\_\_ Date: \_\_\_\_\_

Voucher Type: \_\_\_\_\_ Amount: \_\_\_\_\_ Voucher #: \_\_\_\_\_

Total: \_\_\_\_\_ iMIS ID: \_\_\_\_\_