

APPLICATION FOR CERTIFICATION SCHOLARSHIP

NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
PHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_

EMPLOYMENT

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.*

CURRENT LEVEL OF CERTIFICATION

COA\_\_\_ COT\_\_\_ COMT\_\_\_ I am not certified\_\_\_\_\_  
Proposed date of examination \_\_\_\_\_  
Level of Examination \_\_\_\_\_  
Funding Required (exam fee/travel/lodging/meals) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Special Interests related to ophthalmology: \_\_\_\_\_

*I attest that all information provided in this application is true and accurate to the best of my knowledge.*

\_\_\_\_\_  
Signature Date

Please mail to: JCAHPO Education & Research Foundation, 2025 Woodlane Drive, St. Paul, MN 55125-2998

*Need help completing the application? Have questions?  
You may call Jim Boyne, Foundation Manager, at (800) 284-3937, ext. 249.*