

APPLICATION FOR CERTIFICATION GRANT

NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
PHONE _____

EMPLOYMENT

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: _____

IS YOUR EMPLOYER WILLING TO MATCH FUNDING FOR THE EXAMINATION, DEPENDENT ON COST OF TRAVEL? (Yes) (No) If YES, employer's signature is required.

Employer's Signature Date

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**

Postmark deadline: April 23, 2012