

Application for Examination



Please type or print clearly.

Please refer to the *Criteria for Certification and Recertification* handbook for instructions on completing this application.

1 Examination Type

Please check the examination for which you are applying: COA COT COMT Ophthalmic Surgical Assisting
 ROUB CCOA CDOS

Please check one of the following:

- This is my first time applying for this exam.
- I have taken this exam previously - Last test date: _____ (month / year)
- I am taking this exam to recertify my credential in lieu of continuing education credits.

2 JCAHPO Identification Number (if applicable)

ID# _____

3 Applicant Your name will appear on your certification as written here.

IMPORTANT: *The name on your two forms of identification that will be presented at the testing center when you take the exam must match exactly the name provided below. See page 31 of the Criteria handbook for more information.*

Name: Mr. Mrs. Ms.

Date of Birth: (mm/dd/yy) ____/____/____

First Middle Last Suffix Former name (if applicable)

Home Address: _____ Apt. # _____

City State Zip Code Country

Telephone: _____ Business

E-mail: _____ Home FAX: _____

Note: Notify JCAHPO® of any name or address changes. See page 4 of the Criteria handbook for more information. Official examination results will be mailed to your home address.

Applicant's highest educational credential completed. (Check one box and indicate subject/discipline as appropriate.)

- High school diploma Two-year college (Associate) degree Bachelor's degree Master's degree Other: _____

Subject/Discipline: _____

Applicant's occupational background (Check all that apply.)

- Certified Orthoptist Contact Lens Technician Ophthalmic Photographer Optician Registered Nurse Other: _____

4 Eligibility

Note: Your application will not be processed if the appropriate section below is not completed. See pages 3-4 of the *Criteria* handbook for further explanation of the eligibility criteria. Supporting documentation of your education (such as a transcript or a copy of a certificate of completion) must be attached.

COA Applicants - Check only one box.

- Graduate of formal clinical training program (A1)
- Graduate of formal training program and work experience (A2)
- Completion of independent study course and work experience (A3)

COT Applicants - Check only one box.

- Graduate of formal training program (T1)
- Currently certified as a COA and work experience (T2)
- Currently certified as an orthoptist and work experience (T3)

COMT Applicants - Check only one box.

- Graduate of formal training program and two or more years of college education (TG1)
- Graduate of formal training program, less than two years of college education, and work experience (TG2)
- Currently certified as a COT and work experience (TG3)
- Currently certified as an orthoptist and work experience (TG4)

Ophthalmic Surgical Assisting - Check only one box.

- Graduate of formal clinical training program (SA1)
- On-the-job training (SA2)

ROUB Applicants

- Graduate of formal training program (R1)
- Currently certified by JCAHPO at any core level and work experience (R2)
- Earned CE credits in classroom setting, hands-on course, and work experience (R3)

CDOS Applicants

- Graduate of formal training program (B1)
- Currently certified by JCAHPO at any core level and work experience (B2)
- Earned CE credits in classroom setting, hands-on course, and work experience (B3)

CCOA Applicants

- Completion of independent study course and current employment with supplier of ophthalmic products and/or services.

I comply with the criteria that corresponds to the selection made above and have attached copies of the required documentation.

X _____
Signature Date

5 Payment

Indicate method of payment (please refer to the fee schedule for amount):

Check/Money Order (drawn on a U.S. bank, in U.S. dollars, payable to JCAHPO) VISA MasterCard Discover American Express

If payment is by credit card, please provide the following information:

Security Code: _____

Card Number: _____

Expiration Date (month / year): ____ / ____

Payer's Name (please print): _____ Authorized Signature: X _____

Payer's Billing Address: _____ Payer's Zip Code _____

6 Responsibility Statement

JCAHPO's Responsibility for Certification and Recertification of Medical Personnel Performing Technical Ophthalmic Services for Ophthalmologists

JCAHPO is the federated organization of ophthalmological societies and associations which has been charged with certain responsibilities related to the education and utilization of allied health personnel in ophthalmology. To implement these goals, JCAHPO has established criteria for training, examination, certification, and utilization at various levels of expertise for ophthalmic medical personnel.

Certification by JCAHPO indicates ONLY that the individual has fulfilled the eligibility requirements and successfully completed an examination for which the individual qualifies. Certification by JCAHPO does NOT imply, by any criteria, that the individual is qualified as an independent practitioner.

AGREEMENT OF CERTIFICATION AND RECERTIFICATION

As an applicant for certification or recertification from JCAHPO, I agree to the following:

Numbers 1 and 2 applicable to COA, COT, COMT, Ophthalmic Surgical Assisting, and ROUB applicants only.

- 1. I shall perform, to the best of my ability, those technical ophthalmic services specifically delegated to me by a sponsoring ophthalmologist/physician according to his or her directions, instructions, and prescriptions.
2. I shall provide technical ophthalmic services only in the office of my sponsoring ophthalmologist/physician, a medical clinic, or other medical facility.

Number 3 applicable to CCOA applicants only

- 3. I am currently employed by a corporation that does business within the ophthalmic community and, in my position, I will be interacting with ophthalmic professionals on a continuing basis.

Numbers 4-9 applicable to all applicants

- 4. I authorize JCAHPO to communicate any violation of its rules or standards by me, my status of application or certification, and any matter involving me to state and federal authorities, employers, training programs, and others.
5. I agree not to make and to correct immediately any statements concerning my certification status which are or which become untrue or misleading. I agree to provide JCAHPO confirmation as requested by JCAHPO.
6. I release JCAHPO, its officers, directors, agents, employers, committee members, and others for disciplinary action taken in good faith pursuant to the rules, standards, procedures, and sanctions of JCAHPO.
7. I authorize JCAHPO in its discretion to request information concerning matters relevant to this application and my certification, recertification, and review of certification.
8. I have received and read the rules, standards, procedures and sanctions of JCAHPO. I comply with and agree to be bound by them.

9. Please respond to the following questions:

Yes No Have you ever had a certification or license suspended or revoked?

Yes No Have you ever been dismissed from a job because of alcohol or other drug dependency?

Yes No Have you ever been convicted of a crime?

If the answer to any question in Number 9 is "Yes," include a statement of explanation with the application.

I affirm that all statements made in the above application are true. (Sign and date below.)

X Applicant's Signature Date

7 Employer

All applicants, other than CCOA applicants, complete section A. CCOA applicants complete section B.

SECTION A (for COA, COT, COMT, Ophthalmic Surgical Assisting, and ROUB applicants)

Clinic Name: _____

Main Clinic Street: _____ City: _____ State: _____ Zip: _____

Telephone: _____ FAX: _____

Clinic Manager: _____

First

M.I.

Last

Employer's Practice Setting (Check all that apply)

- Private, Solo Private, Group: Number of Physicians 2-5 6-10 11 or more
 Hospital Clinic or HMO University Clinic Other: _____

Employer's Main Subspecialty (Check only one)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Cataract and IOL | <input type="checkbox"/> Comprehensive Ophthalmology | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Cornea and External Diseases |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Low Vision | <input type="checkbox"/> Neuro-Ophthalmology | <input type="checkbox"/> Ophthalmic Pathology |
| <input type="checkbox"/> Ophthalmic Plastic/Reconstructive Surgery | <input type="checkbox"/> Optical Dispensing | <input type="checkbox"/> Pediatric Ophthalmology/Strabismus | |
| <input type="checkbox"/> Refractive Surgery | <input type="checkbox"/> Retina and Vitreous Disease | <input type="checkbox"/> Other: _____ | |

SECTION B (for CCOA applicants only)

Supervisor's Name: _____

First

M.I.

Last

Company Name: _____

Main Company Address: _____

Product or Service Provided: _____ Supervisor's E-Mail: _____

Applicant's Job Title: _____

8 Sponsor/Employer Endorsement

SPONSORING OPHTHALMOLOGIST ENDORSEMENT FOR COA, COT, COMT, ROUB, CDOS APPLICANTS ONLY

PLEASE CHECK ONE OF THE FOLLOWING: The applicant works under my direct supervision. The applicant has my sponsorship.

(The sponsoring ophthalmologist (or physician for ROUB or CDOS) attests that he/she knows the individual applicant, certifies that the individual is knowledgeable and skilled in the field, and that the individual is working within established JCAHPO guidelines for ophthalmic medical personnel.)

I am an ophthalmologist (or physician for ROUB or CDOS), licensed to practice medicine in: _____
State or Province My license number

X _____
Sponsor's Signature Date

Sponsor's Name (Please print): _____
First Middle Last

Same as your employer address (if not, please complete below)

Clinic Name: _____

Clinic Address: _____

City _____ State _____ Zip Code _____ Country _____

Telephone: (_____) _____ FAX: (_____) _____

EMPLOYER'S ENDORSEMENT (CCOA APPLICANTS ONLY)

The employer/supervisor attests that he/she knows the individual applicant, certifies that the individual is knowledgeable and skilled in the field, and that the individual is working within established JCAHPO guidelines.

X _____
Employer's Signature Date

9 Release of Examination Data

JCAHPO reserves the right to use, for any purpose, all examination data in aggregate reports related to exam performance. Release of such data will not include names or personal, identifiable information. Examples of the purposes, for which such data might be used include, but are not limited to: JCAHPO research projects, grants, and formal training program reports.

Information regarding whether or not you are actively certified is public and may be verified or accessed by anyone.

If you wish to authorize JCAHPO's release of your individual, identifiable data (name) to any source, please contact JCAHPO, in writing, with the name of the intended recipient and the time period in which release can be made.

Compliance with the Americans with Disabilities Act (ADA)

In compliance with the ADA, JCAHPO will provide reasonable accommodations for candidates with disabilities who cannot take the examination under the usual testing conditions. Disabled individuals must provide notice and appropriate documentation (at the applicant's expense) of their disability when applying for the examination.

If accommodations are necessary for you to complete a JCAHPO examination due to functional limitations imposed by a disability, you will be required to complete and return a questionnaire. Questionnaires must be submitted with proper documentation and included with the examination application.

Application Checklist

Before mailing your application, please be sure that the following have been included:

- A copy of documentation showing successful completion of a formal educational training program or independent study course, if applicable.
- A copy of verification of college credits or JCAHPO continuing education credits, if applicable.
- Ophthalmic Surgical Assisting applicants only: A copy of a document showing official accreditation of the surgical facility by a nationally-recognized accrediting agency, if applicable.
- Completion of the appropriate eligibility criteria box, question #9 on section 6, and your signature on application page 2 of 4.
- COA, COT, COMT, Ophthalmic Surgical Assisting, ROUB, and CDOS applicants: Your sponsor's signature (application page 3 of 4). Your sponsor must be an ophthalmologist. If you are applying for the COA, COT, COMT, or Surgical Assisting Exam. ROUB and CDOS applicants may have any physician serve as their sponsor. Original signatures are required - signature stamps or computerized digitized signatures are not accepted.
- CCOA applicants only: Your supervisor's signature (application page 3 of 4). Original signatures are required - signature stamps or computerized digitized signatures are not accepted.
- Examination fee, payable to JCAHPO in U.S. dollars. (Refer to fee schedule). All applications denied due to not meeting the eligibility requirements or incomplete applications, will not receive a refund of the exam fee.

NOTE: Please retain a photocopy of your application. If any of the above-mentioned items are missing or incomplete, your application will not be processed. Mail (DO NOT FAX) your application to:

**JCAHPO
2025 Woodlane Drive
St. Paul, MN 55125-2998**

Once your application is accepted, you will be assigned a 90-day eligibility period. You must schedule and take your examination during this period. This eligibility period, along with information on how to schedule your exam, will be provided to you in a confirmation letter you will receive after your application is accepted.