

APPLICATION FOR ATPO CONTINUING EDUCATION SCHOLARSHIP

NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
PHONE _____ E-MAIL _____
LEVEL OF CERTIFICATION ___ COA ___ COT ___ COA -----NOT CERTIFIED/OTHER (Please list)
ATPO MEMBER # _____

EMPLOYMENT (if applicable)

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.*

FUNDING REQUIRED

Course fees \$ _____
Travel \$ _____
Lodging/meals \$ _____

Special Interests related to ophthalmology: _____

IS YOUR EMPLOYER WILLING TO MATCH FUNDING UP TO \$500, DEPENDENT ON COST OF PROGRAM? (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, and that I have not received financial support from the JCAHPO Education and Research Foundation in the past three (3) years. (PLEASE NOTE: All scholarships, i.e., ATPO and corporate, are distributed by and designated from the JCAHPO Education and Research Foundation.)

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 Carol Kofoed, Foundation/Development Manager, at (800) 284-3937, ext. 246 or 651/731-7246.*