

- Yes, I would like to take the Ophthalmic Coding Specialist Exam.
- Yes, I passed the exam 3 years ago and would like to retain my OCS status.
- Yes, I would like to try again and re-test.

### TEST APPLICANT INFORMATION

**1** Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_ Credential: \_\_\_\_\_ E-mail: \_\_\_\_\_

Address (Exam will be shipped to this address.): \_\_\_\_\_

Job Title (check all that apply):  Administrator/Office Manager  Biller/Coder  MD  COA  
 COT  COMT  Other (please specify) \_\_\_\_\_

**2** Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_ Credential: \_\_\_\_\_ E-mail: \_\_\_\_\_

Address (Exam will be shipped to this address.): \_\_\_\_\_

Job Title (check all that apply):  Administrator/Office Manager  Biller/Coder  MD  COA  
 COT  COMT  Other (please specify) \_\_\_\_\_

### PRACTICE INFORMATION

AAOE Member Number (if applicable): \_\_\_\_\_

JCAHPO ID Number (if applicable): \_\_\_\_\_

Academy Member Number (if applicable): \_\_\_\_\_

Member Name (if different from above): \_\_\_\_\_

Academy Member Email: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Practice Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

# exam pricing

Prices are for AAO and AAOE members, their staff, and JCAHPO certificants.\*

\$175 each

**RE-TEST FEE** \$175 each

**RE-TEST FEE FOR OCS RENEWAL** \$175 each

On-line registration is available at [www.actioned.org](http://www.actioned.org)  
The OCS Exam is listed under "Assessments".

\* Exams and retests are \$300 each for non-AAO member physicians, consultants, sales representatives, optometrists and opticians not employed by Academy-member ophthalmologists.

\*\* MN Residents add 7.125% sales tax.

Name of First Test Applicant:

Total Number of Exams:

Total Cost:\*\*

## METHOD OF PAYMENT

Check or money order payable to JCAHPO     Visa     MasterCard     Discover     AMEX

Card Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Signature of Card Holder: \_\_\_\_\_

Last Name or Company Name:  
As it Appears on Card: \_\_\_\_\_

Security Code:  
(code on back of credit card) \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Card Holder's Billing Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## MAIL OR FAX THIS FORM WITH PAYMENT TO:

Joint Commission on Allied Health Personnel in Ophthalmology  
2025 Woodlane Drive  
St. Paul, MN 55125-2998  
Phone: 800.284.3937  
Fax: 651.731.0410