Please type or print clearly. Please refer to the Criteria for Certification and Recertification handbook for instructions on completing this application.

IJCAHPO Application for Examination

1. Examination Type

Please check the examination for which you are applying: ❑ COA ($300) ❑ COA Practice ($150) ❑ COT ❑ COMT ❑ OSA-ST ❑ ROUB ❑ CCOA ❑ CDOS

Please check one of the following:

❑ Rush fee enclosed. Please refer to the payment section below.
❑ I have taken this exam previously - Last test date:____/____(month / year)
❑ This is my first time applying for this exam.
❑ I am taking this exam to recertify my credential in lieu of continuing education credits

2. JCAHPO Identification Number (if applicable)

ID#_____

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.

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

Home or Mobile Telephone | Business Telephone

E-mail | FAX

NOTE: Notify IJCAHPO of any name or address changes. Official examination correspondence 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: _____

NOTE: Your application will not be processed if the appropriate section below is not completed. See 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)
❑ Currently certified as a COA and non-certified work experience (T4)

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)
❑ Current COT, work experience as a COT, and non-certified work experience (TG5)

OSA-ST Applicants - Check only *one* box.

❑ Graduate of formal clinical training program (SA1)
❑ On-the-job training (SA2)
❑ Approved Surgical Assisting Course(s) and Surgical Log (SA3)

ROUB Applicants

❑ Graduate of formal training program (R1)
❑ Currently certified by JCAHPO as a COA, COT, COMT, or CDOS, 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 as a COA, COT, COMT, ROUB, RDCS, RT(S) or CRA, 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 in the criteria handbook for amount): Discount Code if Applicable:_____

❑ Check/Money Order (drawn on a U.S. bank, in U.S. dollars, payable to JCAHPO) ❑ VISA ❑ MasterCard ❑ Discover ❑ American Express
❑ $50.00 Rush Processing Fee (credit card only)

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

Card Number | Security Code | Expiration Date (month / year)

Payer's Name (please print) | Authorized Signature

Payer's Billing Address | Payer's Zip Code

APPENDIX
IJCAHPO Application for Examination

6. Responsibility Statement

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

IJCAHPO 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, IJCAHPO has established criteria for training, examination, certification, and utilization at various levels of expertise for Allied Ophthalmic Personnel.

Certification by IJCAHPO indicates ONLY that the individual has fulfilled the eligibility requirements and successfully completed an examination for which the individual qualifies. Certification by IJCAHPO 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 IJCAHPO, I agree to the following:

Numbers 1 and 2 applicable to COA, COT, COMT, OSA, CDOS, 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 4-10 applicable to all applicants

4. I authorize IJCAHPO 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 IJCAHPO confirmation as requested by IJCAHPO.

6. I release IJCAHPO, 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 IJCAHPO.

7. I authorize IJCAHPO 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 IJCAHPO. 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 to number 9 is "Yes" include a statement of explanation with the application and a copy of verification to show any penalties have been completed.

10. IJCAHPO examinations are confidential and proprietary. The examination(s) are available to you, the examinee, solely for the purpose of assessing your proficiency level in the content areas referenced in the examination(s) for which you are eligible. You are expressly prohibited from disclosing, publishing, reproducing, or transmitting the examination(s) in any matter, in whole or in part, in any form or by any means, verbal or written, electronic or mechanical, for any purpose. By signing this application you agree to the above disclosure statement. If you do not agree to the disclosure statement and do not sign the application you will not be eligible to take any IJCAHPO examinations.

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, OSA-ST, ROUB, and CDOS applicants)

Clinic Name

Clinic Address | 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 all that apply)

❑ Cataract and IOL ❑ Comprehensive Ophthalmology ❑ Contact Lenses ❑ Cornea and External Diseases

❑ Glaucoma ❑ Low Vision ❑ Neuro-Ophthalmology ❑ Ophthalmic Pathology

❑ Ophthalmic Plastic/Reconstructive Surgery ❑ Optical Dispensing ❑ Pediatric Ophthalmology/Strabismus

❑ Refractive Surgery ❑ Retina and Vitreous Disease ❑ 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, OSA-ST, ROUB, CDOS applicants only)

Please check ONE of the following: o The applicant works under my direct supervision. o 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 IJCAHPO guidelines for allied ophthalmic 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 | First | M.I. | Last

Clinic Name

Clinic Address | City | State | Zip | Country

Telephone | FAX | Email

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 IJCAHPO guidelines.

X_____
Employer's Signature Date

A1. APPENDIX

IJCAHPO Application for Examination

9. Release of Examination Data

IJCAHPO 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 purposed, for which such data might be used include, but are not limited to: IJCAHPO 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 IJCAHPO'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, IJCAHPO 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 IJCAHPO 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 IJCAHPO continuing education credits, if applicable.
- ❑ OSA-ST applicants only: A copy of a document showing official accreditation of the surgical facility by a nationally-recognized accrediting agency, if using the SA2 eligibility pathway.
- ❑ OSA-ST applicants only: Case log of 15 observed category A surgeries if using the SA3 eligibility pathway.
- ❑ Completion of the appropriate eligibility criteria box, question #9 on section 6, and your signature on application pages 1 and 2.
- ❑ COA, COT, COMT, OSA-ST, 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 OSA-ST 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.
- ❑ COT or COMT applicants: If using the T4 or TG5 eligibility pathway, verification of non-certified work experience from your ophthalmologist on letterhead.
- ❑ 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.
- ❑ CDOS applicants only: Case log of 20 abnormal ophthalmic B-scan examinations.
- ❑ Examination fee, payable to IJCAHPO 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:

IJCAHPO
INTERNATIONAL JOINT COMMISSION ON ALLIED HEALTH PERSONNEL IN OPHTHALMOLOGY®

IJCAHPO
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.