

# JCAHPO 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  OSA  ROUB  CCOA  CDOS
- Please check one of the following:
- Rush fee enclosed. Please refer to the payment section below.
  - 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 21 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

Home Telephone Business Telephone

E-mail FAX

**NOTE:** Notify JCAHPO of any name or address changes. See page 7 of the *Criteria* handbook for more information. 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: \_\_\_\_\_

## 4. Eligibility

**NOTE:** Your application will not be processed if the appropriate section below is not completed. See pages 10-19 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)
- 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 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.

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
- \$50.00 Rush Processing Fee

Group Code if Applicable: \_\_\_\_\_

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

# JCAHPO Application for Examination



## 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, 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 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:

- |                              |                             |   |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Have you ever had a certification or license suspended or revoked?</b>                   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Have you ever been dismissed from a job because of alcohol or other drug dependency?</b> |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Have you ever been convicted of a crime?</b>   |

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

10. JCAHPO 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 JCAHPO examinations.

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

X \_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_ Date

# JCAHPO Application for Examination

## 7. Employer

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

### SECTION A (for COA, COT, COMT, OSA, 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 only one)

- 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, 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      First      M.I.      Last

Clinic Name

Clinic Address

City

State

Zip

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

# JCAHPO Application for Examination

## 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 purposed, 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.
- OSA 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.
- 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, 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 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 10 abnormal ophthalmic B-scan examinations.
- 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.*