



Application for Recertification

1 (Please PRINT Clearly or TYPE.)

Applicant Your name will appear on your certificate as written here.

JCAHPO ID# _____

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: (____) _____ (____) _____ Preferred E-mail _____
Home Work

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Employer

CCOA applicants complete section B.

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

Clinic Name: _____

Main 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)

- | | | |
|---|---|--|
| <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: _____

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Certification Category

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COA® CCOA® COT® COMT® ROUB® CDOS™ Ophthalmic Surgical Assisting Assisting in Low Vision

Payment

• Recertification fee is \$115. (\$50 of which is a non-refundable processing fee for cancelled applications. No refunds will be issued for denied applications.)

• If your recertification application is postmarked within the 12 months after your recertification date you will need to include an \$85 late fee.

By Check (drawn on a U.S. bank, in U.S. dollars, payable to JCAHPO) VISA MasterCard Discover American Express (Please do not use debit cards.)

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

Card Number _____ - _____ - _____ - _____ Expiration Date (month / year) ____ / ____

Cardholder's Name _____ 3-Digit Security Code _____
Please PRINT (on back of card)

Cardholder's Address _____
Street City State Zip Code

Authorized Signature **X** _____

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:

Applicable to COA, COT, COMT, Ophthalmic Surgical Assisting, ROUB, and CDOS applicants only

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

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.

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. 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 "Yes", please provide verification of penalty completion.)
- If the answer to any question in Number 8 is "Yes," include a statement of explanation with the application.**

9. I have received and read the rules, standards, procedures and sanctions of JCAHPO. I comply with and agree to be bound by them.
10. I affirm that all statements made in the above application are true. (Sign and date below.)

X _____

Applicant's Signature

Date

Applying for Recertification

A. IF YOU ARE APPLYING FOR THE FIRST TIME:

If you were initially certified at your current level and are applying for recertification for the first time, please submit the following:

1. Completed application, including signatures on pages 2 and 3.
2. List of CE credits earned, including **COPIES** of the evidence of attendance for credits earned.
3. Recertification fee (\$115 for three years).

B. IF YOU ARE NON-CERTIFIED:

Please follow directions under "A".

C. IF YOU WERE GRANTED RECERTIFICATION PREVIOUSLY:

If you applied for and were granted recertification previously at your current certification level or at a less advanced level, please submit the following:

1. Completed application, including signatures on pages 2 and 3.
2. List of CE credits earned (*Please do not include copies of credits unless audited, see "Recertification Audits" below*).
3. Recertification fee (\$115 for three years).

RECERTIFICATION AUDITS

A percentage of recertification applications will be audited. Documentation supporting continuing education (CE) credits earned will be required only of persons whose names are randomly selected for audit. Persons whose names are chosen will be notified within 4 to 6 weeks of the receipt of their application and will be asked to submit, within 30 days, all documentation supporting the number of CE credits required at their certification level. If documentation is not received, they will be considered "non-certified."

ALTERNATIVE TO RECERTIFICATION

You may apply for a computer-based examination at your current certification level. The examination must be completed before the expiration of your certification. Practical tests need not be repeated. The exam application and fees must be submitted.

FOR ALL APPLICANTS

I attest that I have completed the minimum number of hours of continuing education credits required, that documentation is available and will be submitted upon request by JCAHPO, and that the information provided herein is true and correct to the best of my knowledge. I understand that providing false information on this form may result in suspension or revocation of my certification in ophthalmic medical assisting.

X _____
 Applicant's Signature Date

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Sponsor / Employer Endorsement

SPONSOR ENDORSEMENT FOR COA, COT, COMT, ROUB, AND 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 and 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 and 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

