



Association of
Technical Personnel
in Ophthalmology

Please PRINT clearly Mr. Ms. Mrs.

First Name _____ Middle Initial _____ Last Name _____

Certification COA COT COMT ROUB CDOS Other _____

If JCAHPO Certified, ID# _____ Date of Birth ____/____/____

Preferred Mailing Address: Home Work

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Business Name _____ I do not currently work in ophthalmology

Address _____ City _____ State _____ ZIP _____

Position _____ I have been in my current position since _____

Telephone _____ Fax _____

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I am interested in volunteering on a committee. Please contact me.

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