IJCAHPO
INTERNATIONAL JOINT COMMISSION ON ALLIED HEALTH PERSONNEL IN OPHTHALMOLOGY®

Application for Recertification

Please mail (DO NOT FAX) to:
IJCAHPO, 2025 Woodlane Drive, Saint Paul, MN 55125

Please print clearly or type.

1. Applicant Your name will appear on your certification as written here.

NOTE: If you have had a name change, please include a copy of your driver's license.

Name: ❑ Mr. ❑ Mrs. ❑ Ms. Date of Birth: (mm/dd/yy) _____/_____/_____ IJCAHPO ID#: _____

First Middle Last Suffix Former Name (if applicable)

Address Apt. #

City State Zip Code Country

Home or Mobile Telephone Business Telephone E-mail

What race or ethnicity do you identify with most?

❑ American Indian or Alaska Native
❑ Asian or Asian American
❑ Black or African American
❑ Hispanic or Latino
❑ Native Hawaiian or Other Pacific Islander
❑ White or Caucasian
❑ Multiracial or Multiethnic
❑ Other: _____
❑ Prefer Not to Answer

2. Certification Category

❑ COA ❑ CCOA ❑ COT ❑ COMT ❑ ROUB ❑ CDOS ❑ OSA ❑ Assisting in Low Vision

3. Employer CCOA Applicants complete Section B

SECTION A (for COA, COT, COMT, OSA, ROUB, and CDOS applicants only)

Clinic Name

Clinic Address City State Zip Country

Telephone Fax Email

Clinic Manager's First Name MI Last

Employer's Practice Setting (Check all that apply)

❑ Private, solo
❑ Hospital Clinic or HMO
❑ Private, 2–5 physicians
❑ University Clinic
❑ Private, 6–10 physicians
❑ Other:_____
❑ Private, 11 or more physicians

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 First Name MI Last

Company Name

Company Address

Product or Service Provided Supervisor's E-mail

Applicant's Job Title

4. Payment

- The recertification fee is $125. ($50 of which is a non-refundable processing fee. No refunds will be issued for denied applications.)
- If your recertification application is postmarked after your recertification date, you will need to include an $85 late fee.

Indicate the method of payment:

❑ VISA ❑ Discover ❑ Check (drawn on a U.S. bank, in U.S. dollars, payable to IJCAHPO)
❑ MasterCard ❑ American Express

❑ $50.00 Rush Processing Fee (credit card only) (Normal 4–6 weeks, Rush 1 week)

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

Card Number _____ Expiration Date (mm/yy) ____/____ Security Code _____

Billing Address _____ City _____ State _____ Zip _____

Cardholder's Name (please print) _____ X _____ Authorized Signature

5. 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 in 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

6. 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 ($125 for 3 years).

B. IF YOU ARE SUBMITTING AN APPLICATION AFTER YOUR RECERTIFICATION DATE:

Please follow directions under "A" and include an $85 late fee.

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.
3. Recertification fee ($125 for 3 years).

RECERTIFICATION AUDITS

A percentage of recertification applications will be audited. Documentation of 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. Practial 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 IJCAHPO 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.

X _____

Applicant's Signature Date

7. Sponsor/Employer Endorsement

SPONSORING OPHTHALMOLOGIST ENDORSEMENT (for COA, COT, COMT, OSA, 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 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/Province License Number

X _____

Sponsor's Signature Date

_____

Sponsor's First Name MI Last

_____

Clinic Name

_____

Clinic Address City State Zip Country

_____

Telephone Fax Email

EMPLOYER'S ENDORSEMENT (for CCOA applicants only)

The employer/supervisor attests that he/she knows the individual applicant, certifies that the individual is knowledgable and skilled in the field, and that the individual is working within established IJCAHPO guidelines.

X _____

Employer's Signature Date

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Minimum CE Credits Required:
COA/CCOA—18 IJCAHPO Credits
COT—27 IJCAHPO Credits
COMT—36 IJCAHPO Credits
ROUB—25 (minimum 10 related to exam content)
CDOS—25 (minimum 15 related to exam content)

Please note: Courses may only be counted once during a 36-month certification cycle. Duplicate courses will not be accepted.

NAME OF CONTINUING EDUCATION COURSE	PROGRAM SPONSOR	LOCATION/VIRTUAL AND DATE	IJCAHPO CREDITS	ROUB & CDOS CREDITS	
				ROUB & CDOS CONTENT	ROUB & CDOS NON-CONTENT
MAIL (DO NOT send by FAX. Original signatures are required) to: IJCAHPO, 2025 Woodlane Drive, St. Paul, MN, 55125-2998		TOTAL			