215 West Garfield Rd, Ste 200
Aurora, OH 44202-8849
Voice: (330) 995-0718
FAX: (330) 995-0719
Website: www.covd.org

Appendix A

Academic Fellowship (FCOVD-A) Application

Name ____

Office Address ____

City ______________________ State/Country_____________ Postal Code_________________

Office Telephone________________________ Office Fax_________________________________

E-mail Address ____

Undergraduate Education

School ____

Degree received__________________

Year Graduated__________________

Graduate/Professional Education

School ____

Degree received__________________

Year Graduated__________________

School ____

Degree received__________________

Year Graduated__________________

Do you currently provide clinical services to patients? Yes____ No ______

If yes, approximately how many hours per week ________________

I acknowledge that it is the exclusive right of the COVD International Examination & Certification Board to evaluate any and all materials submitted or gathered in the course of the Academic Fellowship process.

I further acknowledge that it is the exclusive right of the COVD International Examination & Certification Board to decide whether this information meets the qualifications for Academic Fellowship.

I understand the acceptance of this application for Academic Fellowship begins my two-year Fellowship program period. If I am unable to complete the process within that time, I may reapply upon payment of an additional application fee.

Signature ____ Date __________________

Updated: May 3, 2016

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FCOVD-A Application Payment Form

Payment must be submitted with application.

FCOVD-A Application Fee: ______ $305.00 COVD Member ______ $390.00 Non-Member

Candidate Name: ____

METHOD OF PAYMENT

____ Check ____ American Express ____ Discover ____ MasterCard ____ Visa

If paying by check: Payment must be drawn on a U.S. bank, in U.S. funds. Make payable to COVD.

If paying by credit card:

Name as it appears on card: ____

Billing Address: ____

____

Credit Card #: ____

Exp. Date: __________ Security # on back (or front) of card: __________

Signature of cardholder: ____

Mail: College of Optometrists in Vision Development
(COVD)
215 West Garfield Road, Suite 200
Aurora, OH 44202

FAX: 330-995-0719

Updated: May 3, 2016