

APPENDIX B

Academic Fellowship Oral Interview Examination Fee Payment Form

Member: \$385.00 _____

Non-Member: \$500.00 _____

Candidate Name (print): _____

Date: _____

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