College of Optometrists in Vision Development
Prevention • Enhancement • Rehabilitation

215 West Garfield Road, Suite 200 • Aurora, OH 44202
Phone: 330 995 0718
Fax: 330 995 0719 • Website: www.covd.org

Fellowship Process Application

Name_____

Address (Office) _____

City _____ State/Country _____ Postal Code _____

Phone (Office)_____ (Home)_____

Email: _____

Optometry School:_____ Year Graduated:_____

Residency Program (if applicable): _____ Year Completed: _____

- **PLEASE ATTACH A CURRICULUM VITAE:** ***A current Curriculum Vitae (CV) including professional activities, lectures, research, published papers, memberships and offices held in professional organizations (optometric and non-optometric) must be submitted with this application.***

- I understand that acceptance of this application for the Fellowship Program begins my four year enrollment period. I hereby warrant that I am **currently licensed** and in good standing in the state/country in which I practice and that I am currently providing clinical testing in the areas of vision and development and performing treatment utilizing vision therapy/rehabilitation. *Please provide the requested information regarding your optometry license in the United States or the International equivalency.*

    - **State of Licensure and License Number:_____**
    - **Licensure Start Date (MM/YYYY):_____**

- I grant permission to the COVD International Examination & Certification Board to communicate with the person selected to be my mentor in order to provide him or her with information about my progress in the Fellowship process.

- I acknowledge that it is the exclusive right of the COVD International Examination & Certification Board (IECB) to evaluate any and all materials submitted or gathered in the course of the Fellowship process. I further acknowledge that it is the exclusive right of the College to decide whether this information meets the qualifications for Fellowship.

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☐ By initialing this box, I attest the application materials are accurate to the best of my ability and I confirm that it is my responsibility to follow the Fellowship Candidate Guide and all processes within. I understand there are absolutely no exceptions made for missed deadlines.

Signature **Date**

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Payment must be submitted with application. ***If payment is made online, please include a receipt with your application submission.***

FCOVD Fee: _____ $300.00 COVD Member _____ $415.00 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