



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



215 West Garfield Rd, Ste 200  
Aurora, OH 44202-8849  
**Voice:** (330) 995-0718 / (888) 268-3770  
**FAX:** (330) 995-0719  
**Website:** [www.covd.org](http://www.covd.org)

## 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