College of Optometrists in Vision Development
Prevention • Enhancement • Rehabilitation

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

Certified Optometric Vision Therapist (COVT) Application

Name _____ Date _____

Address (Office) _____
Street City State Zip

Phone (Office) _____ FAX _____ E-mail _____

Employed by _____ Years of employment _____

EDUCATION

	Name of School	Major course of study	Graduate?	Degree
High School	_____	_____	☐Yes ☐No	_____
College	_____	_____	☐Yes ☐No	_____
Other	_____	_____	☐Yes ☐No	_____

Please submit a copy of your AA or higher degree.

The IECB and/or the Credentialing Director may request a transcript of classes taken to validate the types of courses completed to obtain the AA or higher degree.

Years of experience in vision therapy _____ Hours a week devoted to vision therapy _____ Total VT hours _____

Describe your primary responsibilities in the vision therapy practice including your direct patient contact in vision therapy:

_____

_____

_____

COVT Candidate General Information

In addition to vision therapy, please list any other duties or services you provide for your office.

1. _____
2. _____
3. _____
4. _____
5. _____

Describe how you personally provide therapy:

1. Therapy Sessions
   a. _____ group # in group _____
   b. _____ individual
2. Length of sessions _____ minutes
3. Frequency of sessions _____ per week
4. Average number of therapy patients seen by you each week _____

What type of vision conditions do you personally work with (check all that apply)

_____ Accommodative dysfunction
_____ Binocular dysfunction
_____ Perceptual/learning related problems
_____ Strabismus
_____ Amblyopia
_____ Acquired brain injury
_____ Other _____

I acknowledge that it is the exclusive right of the International Examination and Certification Board of the College of Optometrists in Vision Development to evaluate any and all materials submitted or gathered in the course of the certification process. I further acknowledge that it is the exclusive right of the IECB to decide whether this information meets the qualifications for certification.

_____ _____
Signature of Applicant Date

I certify that the above applicant has the qualifications indicated herein and is performing vision therapy in my office in accordance with the requirements of the IECB. I further agree that I shall notify the COVD office within 10 days should this person's employment in this office be terminated.

_____ _____ _____
Signature of Doctor, FCOVD Printed Name of Doctor, FCOVD Date

The IECB is committed to the spirit and letter of the Americans with Disabilities Act
and will provide appropriate accommodations for those individuals with documented disabilities.

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COVT Application Payment Form

Payment must be submitted with application.

COVT Application Fee: _____ $100.00 COVD Member _____ $125.00 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