



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	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
College	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Please submit a copy of your AA or higher degree if it will apply to hours required to meet eligibility for application.
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 to apply hours towards the total VT hour's requirement.

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

FCOVD ENDORSEMENT OF COVT APPLICANT:

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 please review policy and request form in the Candidate Guide.



COVT Application Payment Form

Payments can also securely be made online in the COVD Store. To receive member pricing you must be logged in to your COVD account.

<https://www.covd.org/store/default.aspx?>

COVT Application Fee: _____ \$100.00 COVD Member _____ \$150.00 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