College of Optometrists in Vision Development

Prevention • Enhancement • Rehabilitation

International Examination and Certification Board

Fellowship Certification Guide

Updated: May 1, 2020

This guide supersedes all older versions.

College of Optometrists in Vision Development
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Table of Contents

I. Welcome

The International Examination & Certification Board (IECB) of the College of Optometrists in Vision Development (COVD) welcomes you as an enrollee in the Fellowship Process. This guide will serve to acquaint you with the background information, references, requirements and procedures for becoming a Board Certified Fellow of the College of Optometrists in Vision Development.

It is strongly recommended that when the candidate begins the Fellowship process, that he/she be thoroughly familiar with this Certification Guide. COVD will post updated versions, which occur annually, as soon as they are available. The updated version supersedes any previous guide.

A. What is a Fellow?

A Fellow has demonstrated advanced competency and is board certified the areas of vision development, vision therapy and vision rehabilitation.

The learning experience you are embarking on will be a rewarding one. Not only will you benefit from expanding your knowledge through guided study, but you will also gain satisfaction through public recognition of your achievement. The section on learning objectives will give you a good overview of the subject areas in which a Fellow has been certified to have advanced knowledge and competence. After you have successfully completed your Fellowship certification, we urge you to stay abreast of advances in the field, as well as encourage you to accept new responsibilities and leadership roles.

B. IECB Mission Statement

The mission of the IECB is to evaluate and certify the advanced competency of optometrists and vision therapists in providing care as related to development and behavior. This mission is accomplished by encouraging continuous learning and providing an evaluation process culminating in the identification of those professionals with demonstrated knowledge and clinical skills in vision care as related to development and behavior. The certification process is designed to encourage professional growth in a collegial environment.

II. Fellowship Process Overview

A. The Fellowship Process

1. Eligibility and Enrollment

- Candidates must be optometrists who have graduated from a school or college that has been accredited by the Accreditation Council on Optometric Education (ACOE), or an international equivalent thereof.
- International Candidates must be optometrists or the equivalent thereof in their country.
- COVD membership is not a requirement to be an eligible candidate for Fellowship, but members are entitled to discounted certification fees and

education discounts.

- The first step is to complete the Fellowship Process Application (Appendix A).
    - Once your application is accepted, your 4 year active candidacy period begins and you may start the Fellowship Process.
    - If a candidate enters a new year during their active candidacy and an updated guide is released, that guide must be used for all remaining work. It is the candidates' responsibility to check the website for the most updated version of the Fellowship guide.
- Once enrolled, you have up to four years to complete the Fellowship process. Candidates may re-apply for additional active candidacy enrollment periods. International candidates may have an additional 2 years to complete the process from their first enrollment period and can also re-apply for additional time. Open Book Question and Case Report fees paid in the initial enrollment periods do carry over to subsequent re-application periods. Only the application fee with updated application is needed to reapply. Subsequent phases will adhere to the current fee structure in the year you complete.
    - **Timeline** – It is your responsibility to follow the Fellowship Timeline (Appendix F) and submit all materials, forms, and fees prior to or on the deadline date, should you plan on completing the process during that year.

2. Phase One: Guided Study

The Guided Study portion of the Fellowship process is designed to facilitate study through completion of six Open Book Questions and three Case Reports regarding patients you have worked with directly in your practice. The goal is to provide you with the opportunity to expand your knowledge base as you discuss your rationale for treatment of different types of visual disorders. You are encouraged to work on the Guided Study requirements at your own pace with your mentor, keeping in mind the deadlines for completion the year you plan to sit for your Oral Interview.

Step 1: This step in the Fellowship process involves documentation that you are experienced in vision development, vision therapy and vision rehabilitation by meeting the following three criteria:

A. You have completed at least 3 years of licensed post-graduate clinical experience, including your year(s) of residency education, if applicable;

B. You have been involved in direct clinical diagnosis and management of office-based vision therapy for 2 years and a minimum of 1000 hours.

C. You have submitted documentation of at least 100 hours of continuing education in vision development, binocular vision, visual perception/visual information processing and vision therapy completed within 5 years prior to your application. The following number of hours can be applied to the 100 hour requirement:

1. Formal CE courses – up to 100 hours
2. Independent study – up to 30 hours. The candidate will provide a list of topics studied and resource material used (textbooks, journal articles, webinars, etc.).
3. Optometric Study Group participation – up to 20 hours. The candidate will provide a list of meetings attended and discussion topics.
4. Credit from completion of a residency program. Those accredited residencies who have components of their program in Vision Therapy including, Brain Injury Vision Rehabilitation, Low Vision Rehabilitation, Pediatric Optometry or Vision Therapy and Rehabilitation, and/or whose Residency Area of Emphasis is either Neuro-Optometric Rehabilitation, Pediatrics, or Vision Therapy and Rehabilitation will be eligible for a percentage of hours waived that equated to the emphasis of VT in their residency; where at least 50% of the time spent doing therapy will equate to the total of 100 hours and 25% of time spent doing vision therapy will equate to 50 hours and so forth. You must document this when submitting your CE with your supervisor approving the amount through an attestation on the submission.

Note: If you have engaged in other activities that added to your knowledge base or clinical skills in the area of VT, please submit the hours. Your submission will be reviewed, by the IECB, to determine if the hours can count toward the CE requirement.

Step 2: Selection of a mentor to work with you throughout the process.

Any active Fellow can serve as a mentor for the Fellowship process. If you need assistance in finding a mentor, the Fellow Mentor Committee Chair can assist you regarding the selection of a mentor to work with. *See Appendix I for contact information, or email cert@covd.org for next steps.*

Step 3: Preparation and Submission of written answers to six Open Book Questions (OBQs) (*OBQs begin on page 11 of this guide)* **AND three written clinical Case Reports** (*Case Reports begin on page 12 of this guide).*

Your answers to the OBQs and Case Reports must be submitted to the COVD office for review by emailing cert@covd.org. It is advised to submit three questions or cases together by each deadline. Fellowship Guided Study Open Book Questions and Case Reports Payment Form (Appendix C) must be submitted at the same time or prior to the first submission of OBQs. This payment can also be made online at www.covd.org/store.

Your mentor must acknowledge in writing that the OBQs and Case Reports have been reviewed and approved by him/her prior to the IECB Review Team receiving the material. Mentors should send approvals directly to cert@covd.org.

The section starting on page 15 of this Certification Guide titled *Format, Submission, and Review Guidelines for Open Book Questions (OBQs) and Case Reports* provides the details of how to submit the OBQs and Case Reports.

Three IECB members will perform a detailed review of your submitted OBQs and Case Reports. These reviewers will provide you with recommendations for additional learning to expand your knowledge on specific topics that will prepare you for Formal Candidacy of the Fellowship process, namely, the Multiple Choice Examination (MCE) and Oral Interview. Your Guided Study materials (OBQs and Case Reports) remain anonymous throughout the review process.

PLEASE NOTE: The review process will take up to eight weeks from the time you submit your OBQs and Case Reports until you receive a letter from the IECB Chair notifying you of whether you have completed the particular OBQ(s) or Case Report(s). Please plan accordingly for revisions when meeting deadlines for completion of certification.

3. Phase Two: Formal Candidacy

The final phase in the Fellowship process consists of the Multiple Choice Examination (MCE) and Oral Interview. The Multiple Choice Examination can be taken at any administration. The exam is administered in June and January, as well as in April at the Annual Meeting. If you decide to take the examination early in the process, the Fellowship Examination Fee Form must be received and processed. (Appendix D), payment can also be made online at www.covd.org/store.

Step 1: Successful completion of the MCE.

The MCE is a 100 question multiple choice test. Candidates are allotted up to 3 hours to complete the examination. International test takers may request additional time. Performance is reported as pass or fail based on criterion-referencing (not graded on a curve—you are not competing against the other candidates in your year). Raw scores are not relevant to the process and are not released. The questions have been written by Fellows and edited for content and clarity, and are analyzed by experts in standardized test design after each test administration.

The following is the percentage breakdown, by clinical topic areas, covered by the MCE, which may be helpful in your preparation for taking the 100 question multiple choice examination:

Clinical Topic Areas	**% of Questions**
Visual Information Processing – diagnosis and treatment	23%
Visual Efficiency/General Skills – diagnosis and treatment	18%
Strabismus – diagnosis and treatment	18%
Amblyopia – diagnosis and treatment	10%
Infant and Preschool Vision Development	10%
General Vision Therapy Concepts	10%
Acquired Brain Injury – diagnosis and management	4%
Special Populations – diagnosis and management	4%
Disease as it relates to Vision Function	3%

Candidates will receive information post-exam on content areas that have been flagged for additional learning based on your scores in those topical areas. These areas are added to your candidate files and IECB reviewers will have access to these flagged content areas for further probing during your Oral Interview.

If a passing score is not received, the examination can be taken again during the next scheduled administration (dates listed on the timeline). Candidates must submit the MCE registration and retake fee prior to the examination.

You have two options for taking the MCE:

Option 1: At an accredited educational institution in your local community. The test must be taken either in June or January during the weeks specified in Appendix F (Fellowship Timeline). You make arrangements with a local college, university, library or learning center to take the exam, and you must supply a qualified proctor. The COVD office will provide you with the requirements expected of a center/proctor and forms that need to be completed to schedule the test administration. If a candidate who uses this option does not pass the MCE, he/she can take another examination, in January if it was attempted in June, or at the COVD Annual Meeting (see Option 2 below). There is an additional cost for multiple attempts. The candidate must contact the COVD office to arrange taking the test.

Option 2: At the COVD Annual Meeting. The test administration is given on the Monday prior to the beginning of the Annual Meeting. The examination start time will be at 1pm and you will have up to 3 hours to complete the exam. Results will be

delivered that evening. If you do not complete the MCE you cannot move into the Oral Interview.

Step 2: Successful completion of the Oral Interview

The oral interview is given only at the COVD Annual Meeting. Interviews are scheduled Monday through Wednesday.

The oral interview is conducted by three IECB members and typically lasts 30 minutes. During the interview, you will be asked questions primarily relating to the reviewers' comments you received about your OBQs and Case Reports and any flagged content areas from the MCE. Should the reviewers have further questions and need more time, an additional interview may be scheduled with two reviewers who were not involved with the first Oral Interview as well as the IECB Chair or Officer. (An original Oral Interview team member will also be present as an observer.) There is no additional fee for a second oral interview.

There is no score or grade that is determined from the Oral Interview. Results of the Oral Interview are used to determine if you have successfully completed the fellowship process.

Step 3: Fellowship Induction

Once you have successfully completed the Multiple Choice Examination and Oral Interview, you are invited to participate in the induction of new Fellows during the induction banquet at the COVD Annual Meeting.

4. **Phase Three: Maintenance of Certification (MOC)**: Certification is good for five years. Fellows are required to maintain every five (5) years.

    - Visit www.covd.org/moc for the most up to date MOC application, criteria and additional topics for education credit.

B. Residents and the Fellowship Process

Doctors in a residency with a program designation of Brain Injury Vision Rehabilitation, Low Vision Rehabilitation, Pediatric Optometry or Vision Therapy and Rehabilitation, and/or whose Residency Area of Emphasis is either Neuro-Optometric Rehabilitation, Pediatrics, or Vision Therapy and Rehabilitation at an accredited school or college of optometry or private practice have the opportunity to take the Multiple Choice Examination (MCE) at the end of their residency. Residents who pass the Multiple Choice Examination are given credit for that portion of the Fellowship process. Further, credit towards the 100 hours of required continuing education will be awarded based on the residency inclusion of vision therapy. Those residencies who have components of

their program that focus in vision therapy will be eligible for a percentage of hours waived that equated to the emphasis of VT in their residency; where at least 50% of the time spent doing therapy will equate to the total of 100 hours and 25% of time spent doing vision therapy will equate to 50 hours and so forth. The Doctors' residency does also count towards the required time in active clinical practice, qualifying for one year of eligibility.

Policy

- Our policy is that residents take the test on a voluntary basis
- A successful completion of the MCE will expire after 5 years. Candidates for fellowship must apply prior to this deadline in order to utilize their MCE for the process.

1. **MCE Schedule for Residents**

    - For in-house residencies, the test must be taken at the same date and time by all residents in an appropriate location at your institution. The exam must not be proctored by an optometrist, optometry student, COVD member, healthcare professional or relative of any candidate.
    - For private practice residencies, the test must be taken at the same date and time in an appropriate location at an accredited educational institution or learning center and proctored by an accredited individual who is not an optometrist, optometry student, COVD member, healthcare professional or relative of any candidate. This method might result in an expense that would be you or your resident's responsibility.
    - The exam must be given at a date and time of your choosing, during the assigned week of the year, typically in June. Contact the International Office for the assigned week or review the published timeline for the year of which you are testing. (See Appendix F: Fellowship Timeline)

2. **Registration for the MCE**

    - **Select a Local Site (this step may be completed by the Residency Director):**

        Contact your local educational institution or testing facility to determine if they can arrange for a qualified proctor to administer the written examination to you. The proctor may not be an optometrist, optometry student, COVD member, healthcare professional or relative of any candidate. You may select the time you wish take the exam.

- **Register for the Written Examination**

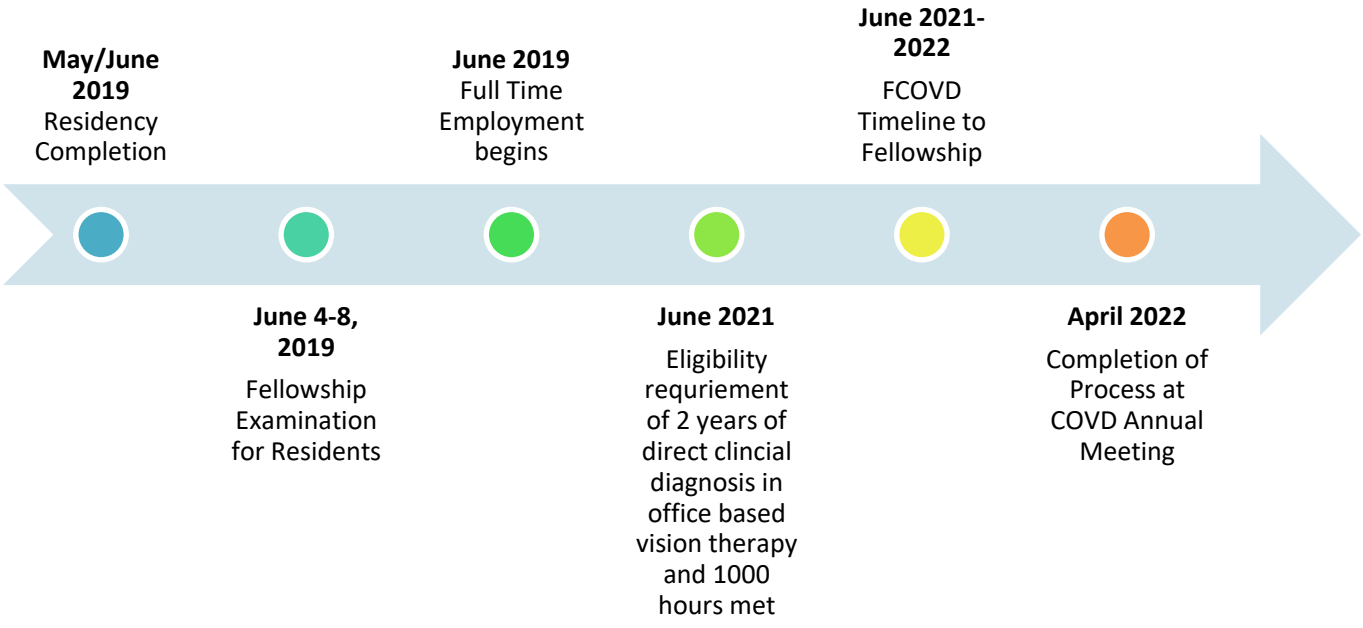
  Once the local site and proctor have been selected, complete the Written Examination Registration Form for Residents and email to Katie@covd.org or fax to the COVD International Office at 330-995-0719.

3. Taking the Written Examination

All testing materials and information will be sent directly to the proctor prior to the test date.

You will need to have photo identification for verification by the proctor. You will not be allowed to bring any materials, notes, books, food, drink, calculators, computers or phones into the examination room. Bring with you several #2 pencils for use in completing the examination score sheet. The proctor will open the sealed envelope containing the examination in your presence and will provide instructions and answer any questions you may have about completing the answer sheet. You will have up to 3 hours to complete the examination.

Resident to Fellow Timeline Sample:



III. Open Book Questions

The Open Book Questions (OBQs) are designed to provide a vehicle through which you communicate your knowledge in the areas of vision development, binocular vision, visual information processing, vision rehabilitation and vision therapy. While vision is a process that involves the integration of all aspects of the visual as well as other sensory systems, certain questions may ask you to isolate one or more aspects of vision in order to evaluate your expertise in this particular area. Candidates must be able to explain their answers with developmental and behavioral rationale for the testing and treatment being described.

It is appropriate to use the words or concepts of others in your answers. However, it is important to clearly state how *you* apply these words or concepts in *your* clinical activities.

If you do not successfully complete an OBQ, the IECB Chair will inform you by email and include the comments from the IECB review team that must be addressed.

Before preparing your answers to the following OBQs, thoroughly read *Format, Submission, and Review Guidelines for Open Book Questions (OBQs) and Case Reports* that starts on page 15. Submissions not meeting the format, and submission guidelines will be immediately returned directly to the candidate for editing without any review from the IECB.

Open Book Questions:

1. From a developmental and behavioral perspective, discuss tests and treatment related to accommodative abnormalities. This may include: accommodative insufficiency, infacility, lack of sustainability, and excess. Discuss how you decide if lenses, prisms and/or vision therapy are indicated and outline your treatment plan.

2. From a developmental and behavioral perspective, discuss tests and treatment related to non-strabismic binocular abnormalities. These conditions may include: convergence insufficiency, convergence excess, and divergence insufficiency, divergence excess, and vertical deviations. Discuss how you decide if lenses, prisms, and/or vision therapy are indicated and outline your treatment plan.

3. From a developmental and behavioral perspective discuss tests and treatment related to strabismus and amblyopia. These tests should include, but not be limited to, evaluation of anomalous correspondence and eccentric fixation. Discuss your treatment modalities for strabismus and amblyopia including occlusion/penalization therapy. Describe how these tests help you decide which treatment is indicated including referral, lenses, prisms and/or vision therapy and outline your treatment plan.

4. Define visual perception and visual information processing. Describe how deficiencies in these areas impact development and performance (e.g., academics, avocation, sports). Discuss your testing of visual information processing and perception; as well as your treatment and management.

5. Discuss the application of lenses and prisms beyond refractive and prismatic compensation. Include the influence of lenses and prisms on visual stress, visual behavior, visual development, and in vision therapy/rehabilitation.

6. Describe your model of vision and how it was derived. Include in it your definition of vision and your understanding of the relationship between developmental milestones, behavior and performance.

IV. Case Reports

Before preparing your case reports, thoroughly read *Format, Submission, and Review Guidelines for Open Book Questions (OBQs) and Case Reports* that starts on page 15. Submissions not meeting the format, and submission guidelines will be immediately returned directly to the candidate for editing without any review from the IECB.

If you have questions about the appropriateness of a case you have selected, please talk to your mentor and if there are still questions, contact the IECB Chair for guidance. The cases you select must be at a stage where treatment is complete, and not be in active progress. You should have been directly involved in management of the case, such as planning therapy activities, loading and unloading (in cases where therapy is involved) so that you are closely involved with care of the patient you present. All clinical findings must be included to support the diagnoses, treatments, and follow-up care. If the outcomes were not optimal, the self-critique must indicate how they could have been improved**. (**See Appendix J for a Sample Case Study Report).

A. Case Report Topics:

1. **<u>Learning Related Visual Perceptual/Visual Information Processing Deficits</u>:** Clinically how do you evaluate and manage children with learning related vision problems? The report must address the role of developmental milestones. The report must also show that the patient has deficits in one or more of the areas of visual perceptual/visual information processing that impact the patient's behavioral development and learning abilities. The deficits must be determined by standardized testing of one or more of these areas. Additionally, but not in lieu of standardized testing, non-standardized measures can be used, such as observation of various patient behaviors and performance. Include any classroom, workplace or daily living recommendations you would discuss with others involved in this patients care. Clearly indicate how your optometric vision therapy addresses these deficits. A case where the patient's deficits that impact learning are primarily because of anomalies of pursuit and/ or saccadic eye movements, and/or accommodation, and/or strabismus and/or non-strabismic binocular anomalies, will not be accepted.

2. **<u>Strabismus</u>**: The report must include the findings of a thorough strabismic diagnostic protocol and a detailed description of the optometric vision therapy that was conducted. The patients' strabismus must be **constant at all times and at all distances**; any instance where there is intermittency of the eye turn is not acceptable (a centration point may be present). Further, the report of a patient whose strabismus resolves as the result of compensatory lenses, such as a fully compensated accommodative esotropia, or the use of minus lenses to induce accommodative convergence in a case of exotropia, is also not acceptable. The patient may or may not have an accompanying amblyopia.

   It is preferable that the treatment has resulted in improvement in cosmesis (reduced amplitude or frequency) and/or in sensory or motor status. **However, if no such improvements were evident, the critique must address the factors that precluded such improvements, what improvements were made, and/or what vision therapy or other management measures could have been taken.** Include the aspects of the development and behavior that you consider important with this patient.

3. **<u>Therapeutic Lens Treatment</u> (Non-compensatory):** The case should include the use of developmental and/or rehabilitative lenses, prisms, filters and/or sector occlusion with no active vision therapy as the treatment. The case should specify the diagnosis (es). Include a discussion of how the treatment impacted the patient's visual stress, visual behavior and visual development. Your case should demonstrate an improvement in performance or development. Follow up visit(s) to evaluate improvements are required. Discussion should include what testing or performance measures led to your lens choice.
   - To note: The various ways lenses are used are described differently by different clinicians. The IECB *does not intend* to establish definitions that other clinicians should use. For this case we will put forth a definition for compensatory in order to better communicate to candidates what the intentions of this case are.
     (1) Definition: compensatory
         (a) A lens prescription whose ***only*** intention is to compensate for a refractive error or strabismic angle is compensatory.
         (b) Such as the following, ***unless*** a behavioral or developmental explanation is included, this type of case will not be acceptable.
             i) A -2.00 myope receives -2.00 lenses.
             ii) A +1.50 hypermetrope receives +1.50 lens.
             iii) Vertical prism is prescribed for a vertical deviation to alleviate diplopia.

B. Required content areas of Case Reports

All case reports must contain the following sections (your final draft *must* address all nine of the content headings listed below). Please limit to no more than 15 pages double-spaced including tables and appendices.

1. Type of Case: (i.e., Learning-related, Strabismus/Amblyopia, or Lens Treatment) Note this on the top of each page.

2. History: Please use the patients' initials (do not use patient's name on any materials). Note the entering complaint, signs and symptoms, onset, frequency and severity of symptoms. Address significant developmental and educational history. Give a brief summary of previous evaluations, pertinent family eye and medical history, the patient's medical history and medications.

3. Diagnostic Data: List all tests by name. List results and observations (quantitative & qualitative). Tests should rule out and define problems.

4. Diagnosis or Diagnoses: Diagnosis should be supported by history, test results, and observations. Relevant interpretation of the data should also be included.

5. Prognosis: The patient's and doctor's goals should be listed. Also, the prognosis for reaching the goals should be provided.

6. Treatment: Write out lenses and prisms initially prescribed and the rationale. Summarize therapeutic procedures including order of implementation and purpose of procedures chosen, frequency of visits, duration of treatment, progress evaluations and resulting changes in therapy process.

7. Outcome of Case: Provide the results of treatment, your impressions of the results, whether patient's goals and doctor's goals were met, and changes in performance.

8. Follow-Up Care: Provide the disposition of case with results, future considerations, final prognosis and subsequent care.

9. Critique: Please address the following questions.
   (A) Are there any general or specific items in this case that did not make sense?
   (B) Are there any additional tests that, in hindsight, you might have performed during the original or progress evaluation(s)?
   (C) Are there any therapeutic techniques you wish you had, in hindsight, utilized?
   (D) Who was more satisfied with the outcome; doctor, patient or patient's family?
   (E) What would you have done differently? What did you learn?

If you do not successfully complete a Case Report, the IECB Chair will inform you by letter and include the comments from the IECB review team that must be addressed. The letter contains instructions regarding the format you must use in addressing the comments.

C. Substitution of Published Case Reports

You may substitute published case reports for the required written case reports if the case report was 1) published in a refereed journal, 2) you were the first author, and 3) it is a

direct substitute for the required case report (e.g., a published case report on the management of an exotropic patient, which included vision therapy as a component of the plan, could substitute for the required case report on strabismus or amblyopia). If you are unsure whether a published case report will qualify, please forward the case report to the IECB for review well in advance of the deadline. The IECB Chair, and officers, will review the potential submission decide whether or not a published case report is acceptable and meets the substitution requirements.

The review committee may ask for a supplement to the published case report to clarify certain aspects of the case (e.g., more detail of the office and home therapy process might be necessary.)

D. Honesty and Social Media Policy

A candidate is expected to be the author of all Case Reports and answers to Open Book Questions as work he/she submits. By seeking credit or recognition for work that is not his/her own, a candidate engages in an act of dishonesty that is a serious offense in a professional community. There are two kinds of dishonesty: cheating and plagiarism. Cheating includes giving or receiving assistance on an examination or assignment in a way not specifically permitted. Plagiarism includes the use of another's scholarship, words, ideas, or artistic product without proper citation or acknowledgment. In all written work, the standard guide for citation or acknowledgment will be The Publication Manual of the American Psychological Association.

Although you must document those you quote, the quote will not be accepted as representing what you think. You must follow a citation with your own thoughts or conclusions and how you apply them clinically.

During the process I will work with colleagues and mentors to formulate responses, however I will not gather answers by soliciting questions to a large body of individuals on social media platforms.

V. Format, Submission, and Review Guidelines for Open Book Questions and Case Reports

1. It is your responsibility to follow the Fellowship Timeline (Appendix B) and submit all materials, forms, and fees prior to or on the deadline date. No exceptions are made for missed deadlines if the candidate seeks to complete the process during that year.

2. All submissions must be sent via email to cert@covd.org and must be written in English.

3. All OBQs and Case Report submissions must use the following format:

    a. Submissions must be typed, 12-point font, double-spaced and submitted as a .PDF

    b. Header: List the assigned candidate number in the header of each page.

i. This is to be the ONLY identifier on your .PDF documents. DO NOT include your name within your document or as a title you use to save your document.

c. Footer: Insert document type and page numbers in the footer of document (Example: *OBQ #1, page 1 of 5* –or- *Case Report [name of case type], page 1 of 15*).

d. Each individual file should be named and saved using your candidate number, followed by the question number. For example: F100000 OBQ 1, or F100000 Case 1

e. All identifying information must be removed from the final submission for anonymity including office letterheads, signatures and coworker and patient identification.

f. <u>OBQs</u>

i. Each response should be no less than one page and no more than five pages, double spaced.

ii. At the top of first page only, type ***OBQ #__*** and **type the question** in its entirety.

g. <u>Case Reports</u>

i. No more than 15 pages, double spaced including tables and appendices.

ii. At the top of first page, list the ***Type of Case*** (i.e., Learning Related Vision Problem, Strabismus or Amblyopia, or Lens Treatment)

4. Write in a clear and concise manner and proofread your materials carefully. Remember to use the spell check.

5. Record the numerical findings and pertinent patient's behavioral changes of all of your clinical tests.

6. Use standard optometric terminology. Reviewers may not understand your clinical "shorthand" or conventions.

7. Photocopies of VT work-ups, chart/file notes are <u>not acceptable</u>.

8. Do not assume that the reviewers know what you are thinking. Please explain your answers and comments in detail, especially with regard to your rationale for diagnosis and management decisions.

9. Each OBQ and Case Report must be submitted as a separate file. Files submitted

which contain more than one OBQ or Case Report will *not* be processed.

10. Mentors *must* read your OBQ responses and Case Reports *prior* to any submission. They must send an email to cert@covd.org stating that they have reviewed and approved your submission(s). The mentor must list the specific OBQ# or Case Report title being submitted which they have approved.

11. You may submit these materials any time prior to the deadline. However, please submit a minimum of what the timeline indicates. For example, if three questions are due, please submit at least 3. Do not submit individual questions.

-Appendix A-

Fellowship 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?

FCOVD Fee: _____ $325.00 COVD Member _____ $425.00 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.

Credit Card Information:

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

-Appendix B-

Fellowship Open Book Questions and Case Reports 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?

FCOVD Fee: _____ $475.00 COVD Member _____ $575.00 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.

Credit Card Information:

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

-Appendix C-

Fellowship Examination Fee 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?

FCOVD Fee: _____ $675.00 COVD Member _____ $975.00 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.

Credit Card Information:

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

-Appendix D-

Summary of FCOVD Fees 2020-2021

COVD Member FCOVD Fees		
Application Fee	$	325.00
Open Book Questions & Case Report Review Fee	$	475.00
Examination Fee[1]	$	675.00
Total - COVD Member FCOVD Fees:	**$**	**1,475.00**

Non-Member FCOVD Fees		
Application Fee	$	425.00
Open Book Questions & Case Report Review Fee	$	575.00
Examination Fee[1]	$	975.00
Total – Non-Member FCOVD Fees:	**$**	**1,975.00**
Multiple Choice Examination Retake Fee[2]	**$**	**250.00**

[1] *includes initial sitting for the multiple choice examination and the oral interview*

[2] *payment must be received for **each** subsequent attempt on the multiple choice examination.*

-Appendix E-

2021 Timeline for Fellow Candidates

Once your Fellowship Application has been accepted, you have up to four years to complete the certification process. Candidates whose primary language is not English, may request a two-year extension to complete the process. **If you plan to take the Multiple Choice Examination and Oral Interview in 2021**, **you must adhere to the following deadlines.**

The COVD 50th Annual Meeting will be held April 12-17, 2021 in Denver, Colorado

Responses to Open Book Questions must be sent electronically following the process guidelines available in the candidate guide at www.covd.org/fellowship. We cannot accept any faxes or alternative methods of submissions.

Normal review process will take eight weeks. If the reviewers request more information (revisions), an additional six to eight weeks may be needed to complete the review process. Please plan submissions accordingly.

June 8, 2020	Three or more Open Book Questions due. Open Book Question and Case Report Review Fee due.
August 14, 2020	Remaining Open Book Questions due
October 12, 2020	All Case Reports due
Revision Deadline Policy	***If revisions are required, you must reply to the reviewers' comments and questions no later than TWO weeks from the date of the IECB Chair's letter if you plan to complete the process this year. Submit mentor approved revisions in the same way you submit OBQs.***

In order to take the Multiple Choice Examination (MCE) and Oral Interview, a candidate must have successfully completed ALL the Open Book Questions and Case Reports, with no outstanding revisions.

January 11-15, 2021	Candidates taking MCE prior to Annual Meeting must take it during the assigned week at a location of your choosing. **Registration for the January MCE must be completed by 12/21/2020.** *Test for RESIDENTS ONLY is currently scheduled for June 8-12, 2020. COVD is monitoring availability of this week due to COVID-19 and will update as needed**
March 5, 2021	All final Open Book Questions and Case Report revisions must be completed to qualify for taking MCE and Oral Interview at the Annual Meeting in April. All outstanding certification fees must be paid.
April 12, 2021	Multiple Choice Examination for candidates taking exam on-site or retaking exam at the Annual Meeting in Denver, Colorado
April 12-14, 2021	Oral Interviews conducted at the Annual Meeting in Denver, Colorado

-Appendix F-

COVD Fellowship Learning Objectives, Critical Concepts and Recommended Study References

The Fellowship process is designed to help you expand your knowledge base in all aspects of behavioral vision care. You will be challenged in your written responses by your mentor and members of the review board. Advanced competency is expected in the following principles and procedures for each clinical condition. The first phase of your fellowship process will help you obtain and articulate a deeper understanding of these principles. It is not required or expected that you will complete the process in one cycle. The examination phase will further explore your understanding of these clinical issues.

1. **Principles and Procedures** – You should be able to define and explain:

    a. The unique qualities, and scientific and clinical principles of each clinical condition.
    b. The epidemiological and demographic characteristics of each clinical condition.
    c. The characteristic history, and signs and symptoms for each clinical condition.
    d. How to assess each clinical condition, including specific test protocols and their interpretation.
    e. The differential diagnosis for each clinical condition.
    f. The specific treatment and management of each clinical condition including:
        1) Prognostic indicators
        2) Treatment options
        3) Duration and frequency of treatment
        4) Treatment philosophy and goals
        5) Specific lens treatment and therapy procedures including rationale for that which is prescribed whether lenses or vision therapy
        6) Ergonomics and visual hygiene
        7) Outcomes to determine successful completion of treatment
        8) Frequency of follow-up care and patient instructions
        9) Referral criteria (medical, neurological, educational, etc.)

2. **Clinical Conditions**

    a. Strabismus and Amblyopia

        1) Amblyopia
            a) Anisometropic / Isometropic Refractive Amblyopia
            b) Strabismic Amblyopia
            c) Hysterical Amblyopia
            d) Form Deprivation Amblyopia

e) Differential diagnoses in childhood visual acuity loss

2) Strabismus
   a) Esotropia
      i. Infantile
      ii. Accommodative
      iii. Acquired
      iv. Microtropia
      v. Sensory
      vi. Convergence Excess
      vii. Divergence Insufficiency
      viii. Non-accommodative
      ix. Sensory Adaptations
   b) Exotropia
      i. Divergence Excess
      ii. Convergence Insufficiency
      iii. Basic Exotropia
      iv. Congenital
      v. Sensory
   c) Vertical Deviations
   d) Noncomitant Deviations (AV Syndrome; Duane's Retraction Syndrome; Brown's Syndrome; III, IV, VI nerve palsy, etc.)
   e) Differential diagnoses in strabismus

3) Special clinical considerations
   a) Anomalous Correspondence
   b) Eccentric Fixation
   c) Suppression
   d) Motor Ranges
   e) Stereopsis
   f) Horror fusionalis/intractable diplopia

b. Growth and Development

1) Visual
   a) Infant vision (normal and abnormal ranges of refractive status in infant, toddler, and preschool populations)
   b) Acuity / Binocularity / Stereopsis / Accommodation
   c) Neurological / Cognitive / Behavioral
   d) Developmental milestones
   e) Piaget stages of development

c. Perception and Visual Information Processing

1) Neurological / Psychological

a) Ambient / focal systems.
b) Visual perceptual midline
c) Parvocellular / Magnocellular function
d) Perceptual Style (central, peripheral)
e) Impact of colored filters
f) Attention

2) Intersensory and Sensorimotor Integration
   a) Visual-auditory
   b) Visual-vestibular
   c) Visual-oral
   d) Visual-motor
   e) Visual-tactual

3) Performance indicators
   a) Laterality and directionality
   b) Visual requirements for academic success
   c) Bilaterality
   d) Gross and fine motor ability
   e) Form perception/visual analysis
   f) Spatial awareness
   g) Visualization
   h) Visual memory
   i) Visual sequential memory
   j) Form constancy
   k) Visual speed and visual span
   l) Visual sequencing

d. Refractive conditions and visual skills

1) Refractive Conditions
   a) Developmental influence on refraction & emmetropization
   b) Aniseikonia
   c) Myopia
   d) Astigmatism
   e) Hyperopia
2) Ocular Motor Function
   a) Eye movements and reading
   b) Pursuit dysfunctions
   c) Nystagmus
   d) Saccadic Dysfunctions
3) Accommodation
   a) Role in myopia development
   b) Role in computer-related asthenopia
4) Fusion in Non-Strabismic Conditions

a) Fixation disparity
b) Motor fusion
c) Sensory fusion

e. Special clinical conditions

1) Acquired brain injury (traumatic brain injury {TBI} and stroke)
2) Developmental disabilities (Down Syndrome, Developmental delay, etc.)
3) Visually induced balance disorders
4) Motor disabilities (Cerebral Palsy, ataxia, etc.)
5) Behavioral disorders
6) Autism spectrum disorders
7) ADD / ADHD
8) Dyslexia and specific reading disabilities
9) Learning Disabilities
10) Computer Vision Syndrome

3. Vision Therapy Concepts to Consider

a. Peripheral awareness: focal / ambient roles
b. Significant findings which are good or poor prognostic indicators of vision therapy and lens application
c. Development, rehabilitation, prevention, enhancement
d. Behavioral lens application
e. Yoked prism rationale for treatment and application
f. The relationship between the visual and vestibular systems
g. SILO/SOLI
h. Visual stress and its impact on the visual system
i. Role of posture in vision development, comfort and performance
j. Disruptive therapy: Discuss this type of therapy and how it can be used as a clinical therapeutic tool.
k. Relationship of speech-auditory to vision
l. How might television, reading, video gaming, restricted movement, computer work, nutrition, etc. impact vision?
m. Perceptual Style, e.g., spatial/temporal, central/peripheral

Study References

The primary resource for writing your responses to the OBQ's and your cases should be your clinical experience. Your writing should not reflect your expertise in quoting back passages from various references but instead your understanding and how you practice. However, you and your mentor may feel that you may benefit from consulting of some of the following reference materials to broaden and deepen your foundation in particular areas. Once you have consulted those mentor-suggested materials and discussed the relevance of that material with your mentor,

you may find your approach to your written work taking on a different and/or more solid approach. The following list of references is only meant as a *potential* guide for the material you may find helpful in building your knowledge base.

Study materials can be downloaded at the following link on the COVD website:
https://www.covd.org/page/Fellowship

Amblyopia/Strabismus

Amblyopia in Problems in Optometry Vol. 3 (2)
Rutstein RP (ed.) Lippincott 1991

Amblyopia – Basic and Clinical Aspects
Ciuffreda K, Levi D, Selenow A. Butterworth – Heinemann 1991

Applied Concepts in Vision Therapy
Press LJ. OEPF 2008

Binocular Anomalies: Theory, Testing & Therapy (5th ed.)
Griffin JR, Borsting EJ. Butterworth-Heinemann 2011 (2 volumes)

Binocular Vision and Ocular Motility: Theory and Management of Strabismus (4th ed.)
von Noorden GK. CV Mosby Co. 1990

Clinical Management of Strabismus
Calaroso E. and Rouse M. Butterworth – Heinemann 1993

Clinical Uses of Prism: A Spectrum of Applications
Cotter S. Mosby 1995

Effective Strabismus Therapy
Greenwald I. OEPF 1979

Strabismus and Amblyopia.
Getz D. OEPF 1990

Pediatrics and Child Development

Clinical Pediatric Optometry
Press LJ and Moore BD. Butterworth – Heinemann 1993

Visual Development and Diagnosis and Treatment of the Pediatric Patient
Duckman R. Lippincott 2006

Developmental Disabilities in Infancy and Childhood. 2nd ed.
Capate AJ and Accardo PJ. Paul Brooks Publishing, 1996

Eye Care for Infants and Young Children
Moore, BD. Butterworths 1997

How to Develop Your Child's Intelligence
Getman G. OEPF

Pediatric Optometry in *Problems in Optometry Vol. 2. (3)*
Scheiman, M editor. J.B. Lippincott 1990

Pediatric Optometry
Jennings BJ, editor. in Optometry Clinics, Appleton & Lange 1996

Principles and Practice of Pediatric Optometry
Rosenbloom AA and Morgan MW. Lippincott 1990

Smart in Everything Except School
Getman GN. OEPF 1992

Your Child's Vision: A Parents Guide to Seeing Growing and Developing
Kavner RS. Simon and Schuster 1985 and OEPF

Vision- Its Development in Infant and Child
Gesell A. Ilg Fl, and Bullis GE. Hafner Publishing Co. 1970

What and how does this child see?
Hyvärinen L and Jacob N. Good Lite and OEPF

Visual Perception, Visual Information Processing, and Learning

Applied Concepts in Vision Therapy
Press LJ. OEPF 2008

Developmental & Perceptual Assessment of Learning – Disabled Children: Theoretical Concepts and Diagnostic Testing
Groffman S, Solan HA. OEPF 1994
Optometric Management of Learning Related Vision Problems 2nd ed.
Scheiman MM and Rouse MW. Mosby 2006

Optometric Management of Nearpoint Vision Disorders
Birnbaum MH. OEPF 2008 (reprinted)

Optometric Management of Reading Dysfunctions
Griffin JR, Chirstenson GN, Wesson MD, Erickson GB. Butterworth – Heinemann 1997

Tests and Measurements for Behavioral Optometrists
Solan HA and Suchoff IB. OEPF 1991

Thinking Goes to School: Piaget's Theory in Practice *
Furth H and Wachs H. Oxford Univ. Press 1975 and OEPF

Vision and Reading
Garzia R. Mosby 1996.

Visual Imagery: An Optometric Approach
Forrest E. OEPF 1981.

Visual Processes in Reading and Reading Disabilities
Willows and Kruk, Lawrence Erlbaum Associates 1992

Refractive Conditions and Visual Skills (Accommodation, Vergence, Saccades, Pursuits)

Accommodation, Nearwork, and Myopia
Ong E and Ciuffreda KJ. OEPF 1997

Applied Concepts in Vision Therapy
Press LJ. OEPF 2008

Binocular Anomalies: Theory, Testing & Therapy (5th ed.)
Griffin JR, Borsting EJ. Butterworth-Heinemann 2011 (2 volumes)

*Clinical Management of Binocular Vision: Heterophoric, Accommodative, and Eye Movement Disorders** 3rd ed
Scheiman M. Wick B. Lippincott 2008

Clinical Uses of Prism: A Spectrum of Applications
Cotter S. Mosby 1995

Eye Movement Basics for the Clinician
Ciuffreda KJ and Tannen B. Mosby 1995

Optometric Management of Nearpoint Vision Disorders
Birnbaum MH. OEPF 2008 (reprint)

Sports Vision: Vision Care for the Enhancement of Sports Performance
Erickson G. Elsevier 2007

Sport Vision in Optometry Clinics Vol. 3 (1)
Classe J. Appleton & Lange 1993

Stress and Vision
Forrest E. OEPF 1988

Vergence Eye Movements: Basic and Clinical Aspects
Schor CM and Ciuffreda KJ. Butterworths 1983

Lens Power in Action
Kraskin R OEPF 2003

Special Clinical Conditions

(Acquired Brain Injury, Developmental Disabilities such as Down's Syndrome, Autism Spectrum Disorders, Motor Disabilities etc.)

Applied Concepts in Vision Therapy (Chapter 12)
Press LJ. OEPF 2008

Neuro-Visual Processing Rehabilitation: An Interdisciplinary Approach
Padula, MW. OEPF 2012

Visual Diagnosis and Care of the Patient with Special Needs
Taub MB, Bartuccio M, Maino DM Lippincott Williams & Williams 2012

Visual and Vestibular Consequences of Acquired Brain Injury
Suchoff IB, Ciuffreda KJ, Kapoor N (eds) OEPF 2001

Clinical Management of Binocular Vision 3r^{d} Edition (Chapter 20)
Scheiman M & Wick VB Lippincott Williams & Wilkins 2008

Envisioning a Bright Future – Interventions that work for children and adults with Autism Spectrum Disorders
Lemer PS (ed) OEPF 2008

Seeing Through New Eyes: changing lives of children with Autism, Asperger's syndrome and other developmental disabilities through vision therapy
Kaplan M. Jessica Kingsley Publishing 2006

Vision Rehabilitation- Multidisciplinary Care of the Patient Following Brain Injury
Suter PS, Harvey Lisa H (eds) CRC Press 2012

Other /Miscellaneous References

Bibliography of Near Lenses and Vision Training Research
OEPF 1998
(This is a softbound text that lists over 1500 references in 64 categories related to behavioral vision care.)

Optometric Clinical Practice Guidelines
Various authors, all are published by the American Optometric Association
- ❖ Care of the Patient with Accommodative and Vergence Dysfunction
- ❖ Care of the Patient with Amblyopia
- ❖ Care of the Patient with Strabismus: Esotropia and Exotropia
- ❖ Pediatric Eye and Vision Examination
- ❖ Care of the Patient with Learning Related Vision Problems

Sources for Study References

American Optometric Association
Items: Optometric Clinical Practice Guidelines
www.aoa.org

http://www.aoa.org/optometrists/tools-and-resources/clinical-practice-guidelines

Bernell/U.S.O 1-800-348-2225
Items: Textbooks
andrews1@midwest.net

Optometric Extension Program Foundation (OEPF) 1-949-250-8070 or 1-800-824-8070
Items: Textbooks and other reprints
http://www.oepf.org/

-Appendix G-

FCOVD Multiple Choice Examination (MCE) Topic Breakdown

The following is the percentage breakdown, by clinical topic areas, covered by the MCE, which may be helpful in your preparation for taking the 100 question multiple choice examination:

Clinical Topic Areas:	**% of Questions**
Visual Information Processing – diagnosis and treatment	23%
Visual Efficiency/General Skills – diagnosis and treatment	18%
Strabismus – diagnosis and treatment	18%
Amblyopia – diagnosis and treatment	10%
Infant and Preschool Vision Development	10%
General Vision Therapy Concepts	10%
Acquired Brain Injury – diagnosis and management	4%
Special Populations – diagnosis and management	4%
Disease as it relates to Vision Function	3%

-Appendix H-

Contact Information:

FCOVD Mentor Committee Chairs

Dr. Kavita Malhotra
DrMalhotra@cox.net

Dr. Mehrnaz Green
drgreen@visiontherapydc.com

COVD International Office Credentialing and Education Director

Katie Kirschner

215 West Garfield Rd., Ste. 200
Aurora, OH 44202
330-995-0718 (phone) 330-995-0719 (fax)
Web: www.covd.org
Email: cert@covd.org

-Appendix I-

Sample Case Report

Case Report #2: Strabismus

History:

M.J., an 18 year- old college student, was referred by a local optometrist for a strabismus evaluation and possible therapy. Her history was significant for a moderate turn in the left eye and mild amblyopia. Her main complaint related to asthenopia associated with reading and computer use. On rare instances she was aware of momentary diplopia. Prior ophthalmologic exams resulted in her parents being told that her vision was good and that the turn was relatively small. No treatment, including glasses, was ever recommended. Since entering college M.J. reported increased visual discomfort due to the amount of reading and computer work required of her. Her health was excellent, with no medications used, and her family's ocular and medical histories were unremarkable.

Clinical findings:

1. Unaided V.A. was O.D. 20/20, O.S. 20/25-3. At near the O.D. was 20/20 reduced Snellen and 20/30 – O.S., reduced Snellen. The O.S. V.A. through a 2.2xTelescope was 20/20+1
2. Unilateral and alternate cover testing at distance, 12^ O.S. Esotropia and 15^ O.S. Esotropia at 16". A repeat of the unilateral cover test at 16" wearing +2.50 sph. O.U. resulted in the esotropia reducing from 15^ to 10^O.S. Esotropia.
3. An unstable centration point was noted at 2" (confirmed by a worth 4 dot test and repeat cover testing) A centration range, extending from 2" out to 5" was noted, beyond which the O.S. suppressed.
4. Motilities were unrestricted, although the O.S. exhibited occasional loss of fixation and periodic "jerky" movements (Maples standards)
5. In the distance, with a +5.00 fogging lens on the right eye, a spontaneous uncrossed (normal correspondence) diplopia was reported.
6. Refraction (dry) O.D. +.75 sph =20/20, O.S. +1.00 sph =20/25-2
7. Distance phoria (with dry refraction prescription in place) yielded an O.S. suppression laterally and vertically.

8. MEM lag = +1.50 O.D., O.S.
9. Cross cylinder =1.00 add O.D., O.S.
10. Near phorias (with+ 2.50 sph O.U.)- intermittent diplopia with unstable fusion at 10^ BO O.S.
11. Amps. O.D. 9 O.S. 2 inches
12. VIsuoscopy unsteady central O.S.
13. Randot Stereopsis no response, Wirt Rings with +2.00 sph. O.U, M.J. perceived ring# 1 correctly, Quoits testing at 6" (through +2.00 sph.) M.J. showed some binocular integration from 2" out to 6". Beyond that distance her performance deteriorated.
14. Bagolini lenses-intermittent O.S. suppression with +2.00 sph OU... The response on Bagolini lenses was consistent with normal correspondence
15. The referring doctor reported that ocular health was negative. His cycloplegic examination did not reveal hyperopia of a greater degree than was evident in my dry refraction.

Diagnosis:

1) Constant, moderate O.S. Esotropia
2) Partly accommodative O.S. esotropia
3) Shallow O.S. strabismic amblyopia
4) Normal Correspondence
5) Accommodative insufficiency
6) Unsteady O.S. direct foveal fixation

Prognosis and goals:

M.J.'s prognosis for improving the O.S.V.A., making near vision activities more comfortable and establishing some binocularity was good. I explained my goals for therapy, (which included developing binocular vision) and M.J. and her parents felt that these were desirable goals. The patient was scheduled for 12 weeks of therapy followed by a reevaluation on week 13. She was advised that therapy might extend to 25 or 30 visits. M.J. indicated that she would be returning to school at the end of her summer break and could only come for approximately 14 sessions.

Twice weekly, therapy was not possible due to financial constraints.

Treatment

Phase one- I asked the referring doctor to provide M.J. with the follow Rx:
O.D. +0.75 sph, O.S. +1.00 sph with a +1.00 add OU in progressive form.

The patient was advised to use this Rx as much as possible. M.J. wore the Rx full time for 2 weeks prior to starting vision therapy (VT). At the first visit a circular piece of translucent tape was placed on the O.D. lens to cover the visible iris area. This was intended to eliminate the need for occlusion and to encourage peripheral binocularity. Office and home VT initially stressed R/G T.V. trainer, Jensen Rock to improve O.S. accommodation, Monocular Accommodative Rock(O.S.) with +/- 1.50 lenses, near-far rock, and the Brock's "streak" technique to reinforce Normal Correspondence (N.C.) and simultaneous awareness. I also loaned M.J. a pair of training glasses (+2.00 sph. O.U.) to wear while doing the pointer and straw technique.

At 10 weeks of VT, cover testing at distance was 10^ O.S. Esotropia and 8^O.S. Esotropia through the add at near. The centration range now extended out to 10" through the add.

At this point I added the Brock string technique with cover/uncover of the O.D. I also gave M.J. a red clip on lens to wear over the O.D. training rx 2 hours daily for antisuppression.

At 13 weeks, I removed the right translucent tape and placed binasal tapes on both lenses. VT now stressed physiological diplopia, prism reader (with red lens on the O.S.) to maintain simultaneous vision. Binocular Accommodative Rock (B.A.R.) with suppression controls was also started.

The O.S. VA was now 20/20-2 at distance and 20/25 reduced Snellen at near through the add. At this time M.J. indicated that reading was much more comfortable. She reported an occasional momentary diplopia when she removed her glasses at night. Since she would be returning to

school shortly, I did a fixation disparity test. Her responses varied between O.S. suppression and an eso "slip" which was neutralized with 8^BO. With an 8^BO before the O.S., M.J. felt that she was using both eyes more easily. I indicated to the patient that a prescription with the prism ground in could be obtained if necessary.
Vergence ranges at this time were as follows:
At distance that BO vergence findings were x/2/-6.
At "16" through+2.00 DS, OU, BI vergence findings were x/8/-10

M.J. returned to school with instructions to continue her home vision therapy and to wear the prescription full time if possible.

When she returned home for her Christmas break she indicated that she had been doing as much home VT as her school schedule allowed. She continued to be asymptomatic with her reading and computer activities.

Her status at this time was as follows: Cover test distance with RX worn= 6^→8^ left Esotropia. with an occasional intermittent movement noted. At near through the add she exhibited a 5^ to 6^ intermittent left Esotropia. Her amps were now OD=9D and OS= 5D. I indicated to M.J. that since she would be home for 5 weeks additional office V.T. would be beneficial. The patient declined any additional office VT citing ongoing family financial constraints and the fact that she was quite comfortable doing all near point activities. A follow up was scheduled when she returned for her summer break.

Self critique

The prescription and VT addressed the patient's asthenopic symptoms and her occasional diplopia, and made her essentially asymptomatic. I would have liked to continue VT to further improve binocularity with and without her prescription.

In reviewing my treatment plan, I could have initially done more monocular OS therapy stressing motilities, accommodative amplitude, hand eye coordination and fixation stability. However, given the patient's time and financial constraints and her increased comfort level the case worked out well.

-Appendix J-

International Examination and Certification Board

Guidelines for Candidates with Disabilities

The International Examination and Certification Board (IECB) of the College of Optometrists in Vision Development, an organization that certifies professionals who specialize in the rehabilitation of individuals with visual disabilities, recognizes its' role in the implementation of the Americans with Disabilities Act (ADA) as amended. The following are guidelines for candidates with disabilities who are applying for test accommodations under the ADA as amended:

- The candidate must inform the IECB of the request in writing, using the *Request for Accommodation* form. Please note that this request must have attached documentation from a qualified evaluator (a physician, psychologist, or optometrist) that demonstrates your disability. Please give your evaluator the *Guidelines for Documentation of Disabilities* to ensure that the IECB has the documentation it needs to comply with the law and to avoid delays in processing your request.
- Please remember to include a personal statement with your form. This personal statement should describe how your disability significantly affects your ability to perform in a standard testing environment.
- Send your Request for Accommodation form, with the personal statement and the evaluator's documentation attached, within 60 days after submission of your Fellowship or COVT Application, to the College of Optometrists in Vision Development, 215 W. Garfield Rd., Ste. 200, Aurora, OH 44202.
- Each request is reviewed and evaluated on an individual basis.
- When the IECB determines that accommodation of your disability is appropriate, they will work with you to determine how best to accommodate your disability for each phase of the examination and certification process.

If you have questions about this process, contact the COVD office at cert@covd.org or phone 330-995-0718).

Information to follow:

Guidelines for Documentation of Disabilities

Request for Accommodations Form

Guidelines for Documentation of Disabilities

The following are guidelines adopted by the COVD International Examination and Certification Board (IECB) for documentation of disabilities for candidates who are applying for test accommodations under the ADA as amended:

- The evaluator must be qualified to conduct the necessary assessments and make the relevant diagnosis or diagnoses. For learning disabilities, this should be a licensed psychologist or psychiatrist who has additional training and experience in the assessment of learning problems in adolescents and adults. For attention disorders, the evaluator should be a licensed psychologist or psychiatrist who has additional training and experience in the assessment of attentional difficulties and the diagnosis of ADHD in adolescents and adults. For physical disabilities, the evaluator should be a physician who has the appropriate training in the relevant specialty area. For vision or hearing disabilities, the evaluator should be an optometrist, ophthalmologist, or audiologist.
- The documentation must be current. Because appropriate accommodations can only be determined based on information about the current impact of the disability on activities of daily living, it is in the candidate's best interest that the information about the impairment be current.
- The documentation must contain the following information:
    - The date of the evaluation;
    - Relevant educational, developmental, and medical history;
    - History of prior accommodation, or rationale for lack of prior accommodation;
    - The tests used to arrive at the diagnosis and the data from these tests;
    - A specific diagnosis or diagnoses that causes impairment, including detailed interpretation of the data and how alternative diagnoses were ruled out, especially in the case of learning disabilities or ADHD;
    - Suggestions for appropriate specific accommodation of the disability;
    - A statement of the qualifications of the evaluator.
- This documentation must be typewritten on the evaluator's letterhead and signed by the evaluator.

Request for Accommodations

Please provide the following information to the International Examination and Certification Board (IECB) of the College of Optometrists in Vision Development to document your request for accommodations under the ADA during the Fellowship or Certified Optometric Vision Therapist certification process:

Name _____
last first middle initial

Gender ❑ male ❑ female

Address _____
street

_____
city state/province ZIP/postal code

_____ _____
daytime phone number e-mail address

Nature of disability

learning impairment:	❑ reading disability ❑ writing disability
language impairment:	❑ receptive language disorder ❑ expressive language disorder ❑ mixed or other language disorder _____
mental health impairment:	❑ attention deficit/hyperactivity disorder ❑ anxiety disorder ❑ other mental health disorder _____
sensory impairment:	❑ visual disability ❑ hearing disability
physical impairment:	❑ mobility disorder ❑ neurological disorder ❑ other physical impairment _____

Accommodation requested (not intended to be a comprehensive list of available accommodations)

❑ extended time on written examination ❑ separate room for written examination

❑ extra breaks during written examination

❑ accommodation during oral examination (please describe) _____

❑ other accommodation (please describe) _____

History of prior accommodation (please check when accommodations were received and describe in your personal statement)

❑ none ❑ optometry school ❑ undergraduate ❑ secondary ❑ elementary

Authorization

I certify that the above and all additional information supplied is true and accurate. I authorize the International Examination & Certification Board of the College of Optometrists in Vision Development to contact the evaluating professional(s) who submitted the attached documentation, or will send documentation under separate cover, of my disability for confirmation, clarification, or further information. I also hereby authorize those professionals to provide the IECB with such information as is necessary to determine the level of disability and appropriate accommodations.

Signature _____ Date _____

Send completed form to: College of Optometrists in Vision Development, 215 W. Garfield Rd., Ste 200, Aurora, OH 44202 or email to: cert@covd.org, or fax to: 330-995-0719

-Appendix K-

Candidate Appeals Policy

The goal of this policy is two-fold:

(1) Resolution of candidate's concerns to the satisfaction of both the candidate and IECB.

(2) Maintenance of candidate confidentiality throughout the process.

When a candidate for Fellowship or COVT has concerns regarding his/her equity of treatment during the certification process, that person will inform the IECB Chair in writing of the concerns. The following procedure will then be followed:

(1) The IECB Chair will convene a group of three Fellows, at least one being a former IECB member, and all of whom are acceptable to the candidate. These fellows (the group) will sign the IECB Confidentiality Form.

(2) The group will be given access to all pertinent written material and given voice or electronic access to the involved IECB members and the candidate.

(3) The group will take no more than three weeks to decide on the validity of the candidate's concerns. They will compose a document that states the reasons for their majority or unanimous decision and forward it to the IECB Chair. The Chair will take appropriate action, and send the group's document to the candidate.

The candidate's signature below indicates that he/she was informed of, and understands the IECB's Appeals Process.

Candidate Signature:_____

Print Name:_____

Date:_____