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 _____

CURRICULUM VITAE: ***A current Curriculum Vitae 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 practicing vision development testing and therapy
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.

☐ By initialing this box, I confirm that it is my responsibility to follow the Fellowship Timeline and submit all materials, forms, and fees prior to or on the deadline date. 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