Candidate Application

Please use your full name as it appears on your government issued I.D.

Last Name: __________________________ First Name: __________________________ MI: __________________________

Company/Organization: (current) ________________________________________________________________

Business Address: _____________________________________________________________

City/State/Zip Code: ____________________________________________________________

Business Telephone: (include area code) __________________________

Home Address: ________________________________________________________________

City/State/Zip Code: __________________________________________________________

Home Telephone: (include area code) __________________________

Email address (REQUIRED): ______________________________________________________

Please indicate the applicable category *

☐ Exam Only – ASOA Member $250  Member # _____________
☐ Exam Only – Non Member $550
☐ Exam and One Year ASOA Membership $500

Payment Information
Select one: □ Check  □ VISA  □ MC  □ AMX  □ DISCOVER  ______ CSV – 3 digits VISA, MC DISC, 4 digits AMX

Name on Card ____________________________________________________________________________

Account Number: _______________________________________________________________________

Expiration Date: _______________________________________________________________________

☐ I authorize ASCRS/ASOA to charge this account for the amount shown above

Cardholder’s Signature: ____________________________________________________________________
**Practice Information:**
Number of non-physician FTE staff members? _______
Number of ophthalmologists? _______
Number of optometrists? _______
Years of ophthalmic management experience: _______
Are you a multi-specialty practice? Yes____ No____
Do you have an ASC? Yes____ No____
What elective services do you offer? ____________________________________________________________

**Americans with Disabilities Act**
Do you have a condition that requires special accommodations for testing? Yes_____ No____
(Per ADA regulations, your condition must be diagnosed by a licensed professional). You are required to submit
your request for special accommodations at least 30 days prior to the examination.

**Experience**
I certify that within the preceding five calendar years, I have at least two years of health care administration
experience and one or more years in ophthalmic practice management.

Signature: __________________________________________

**Employment History**
☐ Health Care Administration ☐ Ophthalmic Practice Management (please use a separate sheet if necessary)

Company/Organization: ________________________________
City/State/Zip Code: ___________________________________________________________________________
Phone: ____________________________ From: ____________ To: ____________________________
Job Title: ______________________________

**Employment History**
☐ Health Care Administration ☐ Ophthalmic Practice Management (please use a separate sheet if necessary)

Company/Organization: ________________________________
City/State/Zip Code: ___________________________________________________________________________
Phone: ____________________________ From: ____________ To: ____________________________
Job Title: ______________________________
I hereby attest the above information is true and accurate

Signature:

Date of Birth (REQUIRED):

You MUST sign the application. Please use your full name as it appears on your government issued I.D.

* Exam Cancellation/Reschedule Fees

Once appointment has been made to take the COE exam the following cancellation/rescheduling fees apply:

6 – or more days prior to scheduled exam date.......................... $25
5 or less days prior to scheduled exam date................................. $95
no show for exam........................................................................ $95

Return application with applicable payment to:

ASOA
4000 Legato Road, Suite 700, Fairfax, VA 22033
or Fax: 703-547-8827
or Email: asoa@aso.org

** Special Consideration for Eligibility

The special consideration process is designed for those applicants whose employment experience does not meet the established eligibility criteria – i.e., within the preceding five calendar years, a minimum of two years of health care administration experience and one year in ophthalmic practice management. People with healthcare administration experience outside the United States may be among those qualifying for special consideration. Special consideration is not offered to applicants who have the opportunity to qualify under established criteria but have chosen not to do so. If you do not meet the eligibility criteria for certification established by the National Board for the Certification of Ophthalmic Executives (NBCOE), but you believe that your education, training and/or experience are equivalent, you may request a special consideration application. Special consideration applications must include the applicant’s resume and/or CV, as well as a statement of why the applicant should be granted special consideration including any available and verifiable professional references. Requests are considered by the NBCOE on a case-by-case basis. Please contact ASOA headquarters for additional information.