

**Before attending a fellowship meeting each candidate must :**

- Fill out the following form and answer all questions that apply then submit these forms to the OAA main headquarters at the address listed at the end of these forms.
- Be given a fellowship Identification number which is used during testing in place of candidates name.
- The fee for Fellowship of \$450.00 US is due before attending the meeting.
- Successfully complete a ten minute phone interview
- At the time of the meeting candidates are required to present proper photo identification (drivers license)

**Application For Candidacy For Fellowship**

Please type or print legibly

**General Information**

Name Of Applicant (Dr./Mr./Mrs./Ms.) \_\_\_\_\_

Date of Application \_\_\_\_\_ Year of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Office Phone \_\_\_\_\_ Fax \_\_\_\_\_

Home Phone \_\_\_\_\_ E-mail \_\_\_\_\_

For the purpose of your over the phone interview please indicate which entered phone number is best to reach you by, and what time and day of the week would you be available.

Mailing Address \_\_\_\_\_

Office Address (if different from above) \_\_\_\_\_

Education: list all educational institutions attended beyond high school, major subjects, and degrees (include year received):

**Please Complete The Following:**

1. How many hours of post graduate education have you received in the past twelve months?
2. How many contact lens patients do you see in a month within your practice?
3. What is the total number of orthokeratology patients you have worked with in your practice?
  - 3a. What kind of topographer do you use?
  - 3b. What fitting sets do you use?
  - 3c. What is the total number of empirical fits you have done?
  - 3d. If you empirically fit, what design do you use the most?
4. How many years have you been a member of the OAA?

**Licensure History**

State(s)/country(ies) in which licensed and year(s): \_\_\_\_\_

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- Are you licensed or certified to administer
- \_\_\_\_\_ Diagnostic pharmaceuticals
  - \_\_\_\_\_ Pharmaceutical agents for treatment purposes

National Board Examination parts passed (give parts and years):

Special credentials or certifications:

Have you been disciplined by any regulatory body or convicted of a felony in any jurisdiction in which you hold a license or right to practice? (Disciplinary measures include revocation of license, suspension of licenses, "cease and desist" notice, reprimand and/or official warning, as well as felony conviction):  
YES \_\_\_\_\_ NO \_\_\_\_\_

If the answer is yes, attach documents or other information which explains the nature of the disciplinary action and the reason for it.

**Professional Activities**

Do you provide clinical services to patients? YES \_\_\_\_\_ NO \_\_\_\_\_

Indicate the approximate percentages of your professional time for each (total should equal 100%):

- \_\_\_\_\_ Private optometric practice
- \_\_\_\_\_ Multidisciplinary setting (other than federal or other governmental)
- \_\_\_\_\_ Optometric educator
- \_\_\_\_\_ Scientist/Researcher
- \_\_\_\_\_ Federal/government service
- \_\_\_\_\_ Other (please list below):

Indicate the approximate percentage of your professional time for each (total should equal 100%):

- \_\_\_\_\_ Binocular vision/vision therapy
- \_\_\_\_\_ Contact lenses
- \_\_\_\_\_ Treatment/management of ocular disease
- \_\_\_\_\_ Low vision
- \_\_\_\_\_ Optometric education
- \_\_\_\_\_ Primary care/general optometry \_\_\_\_\_
- \_\_\_\_\_ Public health/occupational vision \_\_\_\_\_
- \_\_\_\_\_ Vision science/research
- \_\_\_\_\_ Orthokeratology
- \_\_\_\_\_ Optometric education
- \_\_\_\_\_ Other (please list below):

**Applicants who are Optometrists primarily in clinical practice**

Name of Practice \_\_\_\_\_ Number of Years in Present Office \_\_\_\_\_  
Previous Practices \_\_\_\_\_

**Applicants other than those covered in section above**

If you are primarily an optometric educator or vision scientist, please complete the following

Name of institution or other employer \_\_\_\_\_

Rank or Title \_\_\_\_\_ Dates (years) of appointment \_\_\_\_\_

Full-time or part time (percentage) \_\_\_\_\_

Subjects taught (educators) \_\_\_\_\_

Research work you have been engaged in or are now performing:

Other duties and responsibilities:

If you also maintain a clinical practice affiliation, please describe.

If you are not primarily in optometric clinical practice, education or research, please provide a brief description of your history of sustained superior achievement in you contributions to the advancement of orthokeratology:

**Membership affiliations and activities**

List all optometric and other scientific societies in which you have membership:

**Orthokeratology Academy of America Mission Statement**

The Orthokeratology Academy of America is a non-profit corporation, formed to support, promote and advance Orthokeratology by providing quality education and scientific information on the subject of orthokeratology to all interested practitioners. The OAA provides an unbiased forum for the free exchange of ideas and concepts relation to all aspects of Orthokeratology.

A. Members of the Orthokeratology academy of America shall be of good moral character and maintain the highest standards of the profession.

B. Members of the Orthokeratology Academy of America shall accept responsibility for the consequences of their actions, make every effort to ensure that their services are used appropriately and, when indicated, recommend alternate sources of care.

C. Members of the Orthokeratology Academy of America shall maintain the highest degree of professional competence by rendering services that meet the highest standards of practice.

D. The Moral, ethical and legal standards of behavior of a member are a personal matter to the same degree as they are of any other citizen, except as they may compromise the fulfillment of the members professional responsibilities.

E. I hereby agree and subscribe to these standards and apply for candidacy for fellowship in the Orthokeratology Academy Of America.

F. I verify that I have fit at least twenty new orthokeratology patients in my practice.

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Print Name

Signature

Date

Mail to:

Orthokeratology Academy of America  
2853 East New York Ave. Suite B  
Aurora, IL 60504-9090