☐ **Yes, I would like to take the Ophthalmic Coding Specialist Exam.**

☐ **Yes, I passed the exam 3 years ago and would like to retain my OCS status.**

☐ **Yes, I would like to try again and re-test.**

Test Applicant Information

1 **Last Name:** _____ **First Name:** _____

Middle Initial: _____ **Credential:** _____ **E-mail:** _____

Address (Exam will be shipped to this address.)**:** _____

_____

Job Title (check all that apply)**:** ☐ **Administrator/Office Manager** ☐ **Biller/Coder** ☐ **MD** ☐ **COA**

☐ **COT** ☐ **COMT** ☐ **Other** (please specify) _____

2 **Last Name:** _____ **First Name:** _____

Middle Initial: _____ **Credential:** _____ **E-mail:** _____

Address (Exam will be shipped to this address.)**:** _____

_____

Job Title (check all that apply)**:** ☐ **Administrator/Office Manager** ☐ **Biller/Coder** ☐ **MD** ☐ **COA**

☐ **COT** ☐ **COMT** ☐ **Other** (please specify) _____

Practice Information

AAOE Member Number (if applicable): _____

JCAHPO ID Number (if applicable): _____

Academy Member Number (if applicable): _____

Member Name (if different from above): _____

Academy Member Email: _____

Practice Name: _____

Practice Address: _____

City: _____

State: _____

Zip: _____

Phone Number: _____

Fax Number: _____

exam pricing

Prices are for AAO and AAOE members, their staff, and JCAHPO certificants.*

$175 each

Re-test Fee	**$175** each
Re-test Fee for OCS Renewal	**$175** each

* Exams and retests are $300 each for non-AAO member physicians, consultants, sales representatives, optometrists and opticians not employed by Academy-member ophthalmologists.

** MN Residents add 7.125% sales tax.

Name of First Test Applicant:	
Total Number of Exams:	**Total Cost:****

Method of Payment

☐ **Check or money order payable to JCAHPO** ☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **AMEX**

Card Number: _____ **Exp. Date:** _____

Signature of Card Holder: _____

Last Name or Company Name: As it Appears on Card: _____

Security Code: (code on back of credit card) _____

First Name: _____ **Middle Initial:** _____

Card Holder's Billing Address: _____

City: _____

State: _____ **Zip:** _____

Phone Number: _____

MAIL OR FAX THIS FORM WITH PAYMENT TO:

Joint Commission on Allied Health Personnel in Ophthalmology
2025 Woodlane Drive
St. Paul, MN 55125-2998
Phone: 800.284.3937
Fax: 651.731.0410