



## CELMO INITIAL APPLICATION FORM

Application Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phones: O: \_\_\_\_\_ H: \_\_\_\_\_ Cell: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

School/College of Optometry: \_\_\_\_\_ Date of Graduation: \_\_\_\_/\_\_\_\_/\_\_\_\_

Current and Past Licenses and License Numbers:

State	Current?	License #	State	Current?	License #
	Yes/No			Yes/No	
	Yes/No			Yes/No	
	Yes/No			Yes/No	

**Have you been in active practice for three of the last four years?**       Yes       No

List all practice locations:                      Dates of Practice:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Are you in good standing with every state board from which a license is currently held?**

Yes       No      If No, then explain:

\_\_\_\_\_

**Have you had any disciplinary actions taken by any state board or other entity?**

Yes       No      If Yes, then list all disciplinary actions taken:

\_\_\_\_\_

**CELMO will obtain reports from the Healthcare Integrity and Protection Databank (HIPDB) and the National Practitioners Databank (NPDB) regarding the applicant. CELMO will perform primary source verification of credentials.**

Name: \_\_\_\_\_

E-Mail: \_\_\_\_\_

*Please complete the continuing education chart below and attach proof of your 50 hours of continuing education to fulfill the CELMO requirement.*

**COPE Category B: Ocular Disease & Management:** Glaucoma, Peri-operative Management of Ophthalmic Surgery, Refractive Surgery Management, Treatment and Management of Ocular Disease: Anterior Segment, Treatment and Management of Ocular Disease: Posterior Segment.

Minimum – **20 hours with 4 hours CEE** (continuing education with examination).

Date	COPE Course #	Course Title	Location	Administrator	# Hours	# CEE Hours
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Total Group B = \_\_\_\_\_ Total CEE Group B = \_\_\_\_\_

**COPE Category C: Related Systemic Disease:** Neuro-Optometry, Pharmacology, Principles of Diagnosis, Systemic/Ocular Disease.

Minimum – **20 hours with 4 hours CEE** (continuing education with examination).

Date	COPE Course #	Course Title	Location	Administrator	# Hours	# CEE Hours
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Total Group C = \_\_\_\_\_ Total CEE Group C = \_\_\_\_\_

**THE REMAINING 10 HOURS FROM ANY COMBINATION OF COPE Category A:  
Clinical Optometry: Contact Lenses, Functional Vision/Pediatrics, General Optometry, Low  
 Vision or COPE Category B or COPE Category C:**

<b>Date</b>	<b>COPE Course #</b>	<b>Course Title</b>	<b>Location</b>	<b>Administrator</b>	<b># Hours</b>	<b># CEE Hours</b>
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Total of the Optional Combination of Groups A, B, and C = \_\_\_\_\_

**Please fax or mail the continuing education chart and proof of your 50 hours of continuing education fulfillment to:**

**ARBO  
 200 South College Street, Suite 1630  
 Charlotte, NC 28202  
 Phone: 704-970-2710  
 Fax: 704-970-2720**



***Please enclose a check for \$50 for INITIAL fee. Make checks payable to CELMO.***

For payment by credit card:

Circle One:                      VISA                      MASTERCARD                      AMEX

Account Number: \_\_\_\_\_

Name as Printed on Card: \_\_\_\_\_

Signature: \_\_\_\_\_

Mail to:                      ARBO  
   Attn: CELMO  
   200 South College Street  
   Suite 1630  
   Charlotte, NC 28202

I hereby certify that the responses in this attestation and information in the documents are accurate, complete and current as of this date. Any material change in this information will be reported to CELMO.

I understand that any submission of fraudulent information or failure to submit material information will result in immediate denial or rescission of the CELMO certificate and such action shall be reported to all applicable State Boards.

I do hereby authorize CELMO to utilize and distribute this information as CELMO deems necessary in order to process and evaluate my application and to contact any state board, school or college of optometry, and/or any other entity to verify any information submitted by or about me.

Signed: \_\_\_\_\_

Direct Telephone: \_\_\_\_\_

Date: \_\_\_\_\_