



children's
EYE CARE

John D. Roarty, MD
Rajesh C. Rao, MD
Lisa Bohra, MD
Leemor B. Rotberg, MD
Elena M. Gianfermi, MD
Alexandra O. Apkarian, MD
Shaza Al-Holou, MD
Amanda Ismail, MD
John D. Baker, MD

Student Application for Children's Eye Care of Michigan Orthoptic Program

Date _____

Name Last _____ First _____ Middle _____

Address _____

City/State/Country/Zip Code _____

Phone Day () _____ Night () _____

E-mail _____

Date of Birth _____ Birthplace _____ Citizenship _____

Do you have or have you had any illness or physical limitations that might interfere with your training as an orthoptic student? (Please explain)

Educational Background

List chronologically from high school to present:

Date enrolled	School/University	Location	Degree/Major field
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CLINTON TOWNSHIP
42700 Garfield Rd
Suite 200
Clinton Township, MI 48038
T 586.532.3380
F 586.416.1608

DEARBORN
22731 Newman St
Suite 245
Dearborn, MI 48124
T 313.561.1777
F 313.561.8044

WEST BLOOMFIELD
7001 Orchard Lake Rd
Suite 200
West Bloomfield, MI 48322
T 248.538.7400
F 248.538.7403

DETROIT
Children's Hospital of Michigan
Department of Ophthalmology
3901 Beaubien Blvd
Detroit, MI 48201
T 313.745.3937
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REFERENCES

1. Name _____ Phone _____ Email _____

Mailing Address _____

Years Known _____ Relationship to applicant _____

2. Name _____ Phone _____ Email _____

Mailing Address _____

Years Known _____ Relationship to applicant _____

3. Name _____ Phone _____ Email _____

Mailing Address _____

Years Known _____ Relationship to applicant _____

Have you had any experience working in an ophthalmology clinic or other eye care facility? If so, please describe the amount of time and experiences:

Have you ever worked closely with small children? If so, please describe the amount of time and experiences:

How did you hear about orthoptics as a career? Why does this field interest you?

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PEDIATRIC OPHTHALMOLOGY + ADULT STRABISMUS

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Enclose with this application:

1. A brief autobiographical sketch (less than 300 words), handwritten by the applicant on a separate sheet of paper
2. A recent photograph

Please forward:

1. All college transcripts
2. Proof of certification(s), if applicable
3. Three letters of recommendation

Send the fully completed application and enclosures to:

Mary DeYoung-Smith, CO, COMT, Orthoptic Program
c/o Children's Eye Care, PC
6689 Orchard Lake Rd #297
West Bloomfield MI 48322

or email marys@cecmich.com

I certify that all information provided on this application form and all other admission materials are complete and accurate to the best of my knowledge.

Applicant's Signature _____ Date _____

The Orthoptic Program at Children's Eye Care will consider all qualified applicants regardless of race, color, religion, gender, or national origin. Qualified applicants with disabilities will be equally considered unless their attendance, clinical performance, or academic ability is appreciably compromise.

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