I, Dr. ________________________________, a member of the Pennsylvania Optometric Association, agree to adhere to the conditions and requirements of the Children’s Vision Care Alliance as set forth in this letter of agreement.

Conditions & Requirements

1. I shall provide expedient and accessible scheduling for all children.

2. I shall promote the alliance with other eye care and healthcare professionals.

3. I shall communicate the results of the child’s eye examination to the respective parents, school nurses, and healthcare professionals involved in the care of the child as appropriate.

4. I shall follow the optometric standards set forth in the American Optometric Association’s Evidence-based Clinical Practice Guidelines.

Wherefore, I hereby sign and agree to the conditions and standards of this agreement.

_________________________________________  ______________
Doctor’s Signature                     Date

I provide the following vision services: (Check all that apply)

☐ Vision Therapy  ☐ Low Vision  ☐ Infants

Pennsylvania Optometric Association
218 North Street • Harrisburg, PA 17101
(717) 233-6455 phone • (717) 233-6833
www.poaeyes.org