# Optimum VA

NAVAO Newsletter Winter 2005

## News and Notes



## 99202



## Editor's Box



## Web Links



# Leave Policy Changed

Reductions in the annual and sick leave accrual rates highlight the 2006 leave changes for Title 38 physicians, dentists, optometrists, podiatrists, and chiropractors. Other changes include:

- Eliminate leave charges for administrative non-duty days;
- Reduce the annual leave accrual rate from 30 days to 26 days per leave year (equivalent to 5 weeks and 1 day of annual leave);
- Reduce the amount of the maximum annual leave carryover from 120 days to 86 days into the next leave year (equivalent to 17 weeks and 2 days of annual leave). All leave over 86 days will be placed in a separate account and paid out as it was earned 7 days per week. If the employee has 120 days of accrued leave, 34 days will be "frozen" (this equates to 4.86 weeks of annual leave (34/7). Employees will receive a lump-sum payment for any remaining unused "frozen" leave upon separation or retirement;
- Reduce the sick leave accrual rate from 15 days to 13 days a leave year (equivalent to 2 weeks and 3 days of sick leave);
- Include provisions for eligible employees to use extended sick leave (up to 12 administrative workweeks/60 days) to care for a family member with a serious health condition; and
- Reduce the number of days that annual leave can be advanced from 30 to 26 days. (continued)

## NAVAO Officers Announced

Congratulations to the incoming NAVAO Officers.

Dr. Gay Tokumaru (President)
Dr. Brian Kawasaki (Vice-President)
Dr. Michael Huang (Treasurer)
Dr. Michael White (Secretary).

Officers continuing in their roles during the upcoming year will be:

Dr. Ken Myers (Executive Director)
Dr. Rebecca Sterner (Membership Director)
Dr. Jim Williamson (Newsletter Editor)
Dr. Minna Huang (Events Coordinator).

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## Leave Policy Changes (cont.)

In addition, the policy change will also reflect that sick leave, not to exceed 360 hours, may be advanced to nurses, nurse anesthetists, physician assistants and expanded-function dental auxiliaries. It is expected that the policy change will be effective in Leave Year 2006. Human Resources offices will be notified accordingly upon approval of the policy change. Veterans Health Administration and Payroll Policy will issue separate guidance on the use of "frozen" leave accounts.

For questions concerning this notice please contact Katie McCullough-Bradshaw at (202) 273-9836; Matilda Bruno-Gaston, (202) 273-5938; Willie Swailes, (202) 273-9036 or Francene Shelton at (202) 273-4943.

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## Highlights from the NAVAO Business Meeting and Banquet

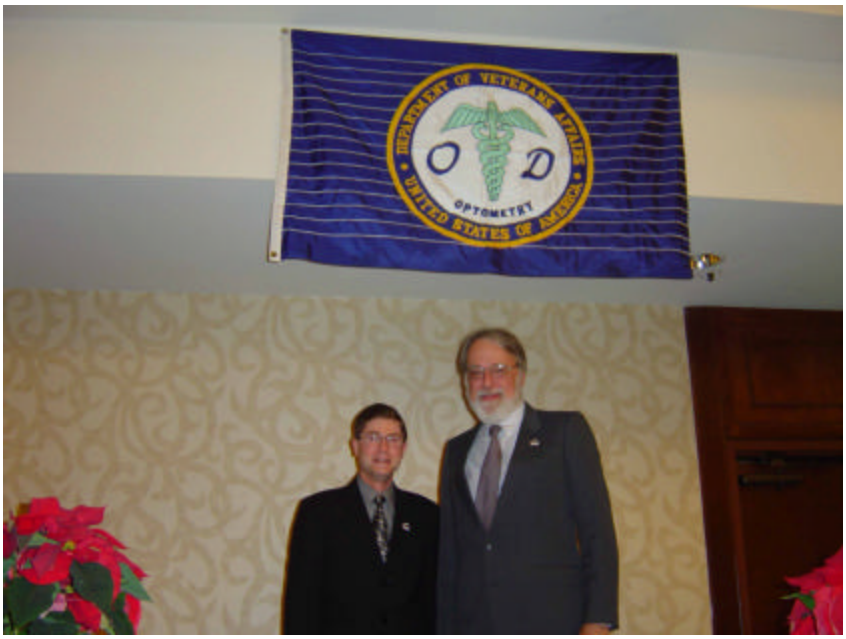
**Brian Kawasaki, OD, FAAO**

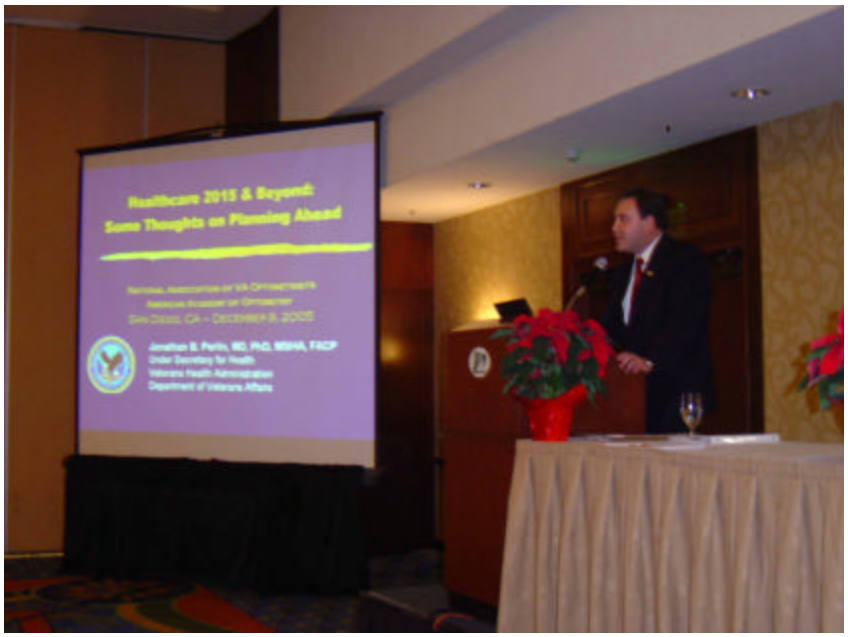
The annual NAVAO Business Meeting and Banquet was held at the San Diego Marriott Hotel & Marina. Thanks to Alcon for their generous funding of our dinner and continued support of VA Optometry. NAVAO President Dr. Sharon Atkin presided at the Business Meeting. Dr. Atkin thanked Dr. Aly Wasik, Vice-

President of the NAVAO, for her outstanding job of presiding over last year's NAVAO meeting at Tampa during her absence. She also thanked Dr. Minna Huang, NAVAO Events Coordinator, for her excellent work in organizing the annual NAVAO Business Meeting, Reception, and Banquet.

- Dr. Tom Golis, NAVAO Treasurer, reported that we currently have $27,000 in our account.
- Dr. Stacia Yaniglos distributed CD's containing information relating to VISTA imaging.
- Dr. Paul Freeman, Editor of *Optometry – Journal of the American Optometric Association*, presented this year's Eagle Award to Michael Sullivan-Mee, OD, and others for their article "The Relationship Between Central Corneal Thickness-Adjusted Intraocular Pressure and Glaucomatous Visual-Field Loss."
- NAVAO members agreed to an invitation from the American Optometric Student Association that the NAVAO become Sustaining Members at $100 per year.
- Dr. Atkin informed us about a change in VA policy as it relates to annual leave. Beginning January 1, 2006, Title 38 physicians will receive 26 days of annual leave per year and will only be allowed to accumulate 86 days total. In return, employees will not be charged annual leave for weekends that are bracketed by annual leave on Fridays and Mondays. Please check with your local HR department for further details.
- Dr. Atkin announced the newly elected NAVAO Officers for 2005-2006: Dr. Gay Tokumaru (President), Dr. Brian Kawasaki (Vice-President), Dr. Michael Huang (Treasurer), and Dr. Michael White (Secretary). Officers continuing in their roles during the upcoming year will be Dr. Ken Myers (Executive Director), Dr. Rebecca Sterner (Membership Director), Dr. Jim Williamson (Newsletter Editor), and Dr. Minna Huang (Events Coordinator). Dr. Atkin also recognized Drs. Wasik and Golis for their outstanding service as outgoing Vice-President and Treasurer respectively.
- Several presentations were made at the NAVAO banquet following the Business Meeting and Reception.
    - Dr. John Townsend, Chief of the VA Optometry Service, presented Certificates of Appreciation to Drs. Matt Cordes, Anthony Ficarra, Anthony Litwak, Luke Lindsell, Dawn Pewitt, and Kathy Wang for their efforts towards the advancement of the VA Optometry Service.
    - Dr. Townsend also recognized Drs. Sharon Atkin, Anthony Ficarra, Mary Jo Horn, Tim Messer, John Tierney, and Nathan Whitaker for their work on the Optometry Strategic Planning Committee.
    - In addition, Dr. Townsend acknowledged Dr. Sam Belkin for his continued work with the VA Advanced Clinic Access (ACA) initiative.
    - Also, Dr. Larry Davis, President of the Association of Schools and Colleges of Optometry, read a proclamation and presented a certificate to Dr. Myers on behalf of ASCO.

- Dr. Ken Myers was recognized for his outstanding commitment and dedication to the VA Optometry Service in honor of his recent retirement.




Our keynote speaker was the Honorable Jonathan B. Perlin, MD, PhD, MSHA, FACP, the Undersecretary for Health of the Department of Veterans Affairs. During his interesting and inspiring presentation entitled "Healthcare 2015 and Beyond: Some Thoughts on Planning Ahead," Dr. Perlin discussed the progress the VA has made over the years, the contributions that the VA has made to healthcare industry, and the future of VA healthcare. Dr. Perlin also presented a VA Coin to Drs. Townsend and Atkin for their dedication to the mission of the VA and its Optometry Service.

Dr. Jack Terry, Executive Director of the National Board of Examiners in Optometry, presented findings from the first administration of the Advanced Competency in Medical Optometry Exam. Sixty-three individuals took the test in June 2005 with an approximate pass rate of 90%. The ACMO will be offered again on June 10, 2006. The banquet concluded with a presentation by Dr. Wasik to Dr. Atkin on behalf of the NAVAO for her service over the past two years as president of NAVAO.

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# Thanks

**Sharon Atkin, OD**

(*Editor's Note: The following is an excerpt from an email received from Dr. Atkin in October 2005)*

It has been an honor to serve as President of such an outstanding group of individuals. I would like to thank my fellow officers and board members for their contributions and dedication. I greatly appreciate the time and effort these individuals have given on behalf of NAVAO. It is impossible for the President to function without the contributions of the entire team.

Vice-President Aly Wasik
Secretary Michael White
Treasurer Tom Golis
Past-President Jerry Selvin
Membership Director Rebecca Sterner
Newsletter Editor James Williamson
Banquet Director Minna Huang
Executive Director Ken Myers

Thanks again for the support provided by my fellow officers and board members as well as to the entire membership.

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## CMS Now Has Formulary

For the first time ever, everyone with Medicare, regardless of income, health status, or prescription drug usage, will have access to prescription drug coverage. This new coverage begins on January 1, 2006.

There are two ways to get Medicare drug coverage. Enrollees can add drug coverage to the traditional Medicare plan through a "stand alone" prescription drug plan. Or they can get drug coverage and the rest of their Medicare coverage through a Medicare Advantage plan, like an HMO or PPO, that typically provides more benefits at a significantly lower cost through a network of doctors and hospitals. In order to help enrollees chose a plan, a Landscape of Local Plans categorized by State and County has been established.

With the recent addition of Medicare's Part D, providers must be informed about enrollee's drug choices. There are currently two ways to access the CMS formulary:

www.epocrates.com
http://formularyfinder.medicare.gov/formularyfinder/selectstate.asp

Enrollment for the plan began November 15 and will run through May 15, 2006.

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## Increased Amino Acid Levels = Increased AMD Risk

People who have elevated homocysteine in their blood, an amino acid which is a known biomarker for cardiovascular disease, may also be at an increased risk of developing age-related macular degeneration, according to a study in the January issue of the American Journal of Ophthalmology.

In this largest study of the relationship of this amino acid and AMD, researchers measured the fasting plasma homocysteine levels of 934 individuals who were participating in an ancillary study of the Age-Related Eye Disease Study. Five hundred and forty seven people with AMD and 387 control subjects were tested at the Massachusetts Eye and Ear Infirmary (Boston, Mass.) and Devers Eye Institute (Portland, Ore.).

"We found that elevated homocysteine in the blood may be another biomarker for increased risk of AMD," said lead author Johanna M. Seddon, M.D., director of Epidemiology at the Massachusetts Eye and Ear Infirmary who is also an associate professor of ophthalmology at Harvard Medical School and at the Harvard School of Public Health. "Homocysteine can be reduced by dietary intake of vitamins B6, B12 and folate, so the relationship between this amino acid and AMD deserves further study."

**http://www.meei.harvard.edu/what/press.php#seddon06**

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## More Chest Compressions Among Changes

Simplifying CPR instruction and increasing the number of chest compressions delivered per minute are just a few of the changes in the recently released 2005 CPR guidelines. Following are some of the most significant new recommendations in these guidelines:

- Elimination of lay rescuer assessment of signs of circulation before beginning chest compressions: the lay rescuer will be taught to begin chest compressions immediately after delivering 2 rescue breaths to the unresponsive victim who is not breathing (Parts 4 and 11).
- Simplification of instructions for rescue breaths: all breaths (whether delivered mouth-to-mouth, mouth-to-mask, bag-mask, or bag-to–advanced airway) should be given over 1 second with sufficient volume to achieve visible chest rise (Parts 4 and 11).
- Elimination of lay rescuer training in rescue breathing without chest compressions (Parts 4 and 11).
- Recommendation of a single (universal) compression-to-ventilation ratio of 30:2 for single rescuers of victims of all ages (except newborn infants). This recommendation is designed to simplify

teaching and provide longer periods of uninterrupted chest compressions (Parts 4 and 11).

- Modification of the definition of "pediatric victim" to preadolescent (prepubescent) victim for application of pediatric BLS guidelines for healthcare providers (Parts 3 and 11), but no change to lay rescuer application of child CPR guidelines (1 to 8 years).
- Increased emphasis on the importance of chest compressions: rescuers will be taught to "push hard, push fast" (at a rate of 100 compressions per minute), allow complete chest recoil, and minimize interruptions in chest compressions (Parts 3, 4, and 11).
- Recommendation that Emergency Medical Services (EMS) providers may consider provision of about 5 cycles (or about 2 minutes) of CPR before defibrillation for unwitnessed arrest, particularly when the interval from the call to the EMS dispatcher to response at the scene is more than 4 to 5 minutes (Part 5).
- Recommendation for provision of about 5 cycles (or about 2 minutes) of CPR between rhythm checks during treatment of pulseless arrest (Parts 5, 7.2, and 12). Rescuers should not check the rhythm or a pulse immediately after shock delivery—they should immediately resume CPR, beginning with chest compressions, and should check the rhythm after 5 cycles (or about 2 minutes) of CPR.
- Recommendation that all rescue efforts, including insertion of an advanced airway (eg, endotracheal tube, esophageal-tracheal combitube [Combitube], or laryngeal mask airway [LMA]), administration of medications, and reassessment of the patient be performed in a way that minimizes interruption of chest compressions. Recommendations for pulse checks are limited during the treatment of pulseless arrest (Parts 4, 5, 7.2, 11, and 12).
- Recommendation of only 1 shock followed immediately by CPR (beginning with chest compressions) instead of 3 stacked shocks for treatment of ventricular fibrillation/pulseless ventricular tachycardia: this change is based on the high first-shock success rate of new defibrillators and the knowledge that if the first shock fails, intervening chest compressions may improve oxygen and substrate delivery to the myocardium, making the subsequent shock more likely to result in defibrillation (Parts 5, 7.2, and 12).
- Increased emphasis on the importance of ventilation and de-emphasis on the importance of using high concentrations of oxygen for resuscitation of the newly born infant (Part 13).
- Reaffirmation that intravenous administration of fibrinolytics (tPA) to patients with acute ischemic stroke who meet the NINDS eligibility criteria can improve outcome. The tPA should be administered by physicians in the setting of a clearly defined protocol, a knowledgeable team, and institutional commitment to stroke care (Part 9).
- New first aid recommendations (Part 14).

http://circ.ahajournals.org/content/vol112/24_suppl/

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## What Medical Students Perceive as Important

Researchers at the University of Colorado attempted *t*o determine the perceived importance among medical students of various selection criteria for residency. Medical students at three institutions were asked to rate the importance of various residency selection criteria using a web-based survey instrument. Sixteen residency selection criteria were included in the survey. The overall response rate was 49.2%.

Criteria perceived as extremely important by the majority of students were the interview (80.6%), grades in third and fourth year courses in their chosen specialty (73.3%), letters of recommendation excluding the Dean's letter (65.3%), and grades in third and fourth year clerkships (55.9%). USMLE Step 1 score (46.7%) was viewed as extremely important by many students.

Moderately important: grades in fourth year electives not in their chosen specialty (57.3%), medical school's reputation (50.5%), number of honor grades (49.0%), USMLE Step 2 score (42.3%), and Dean's letter (41.1%).

Mildly/not important: grades in the first and second years (56.8%), academic awards (55.2%), extracurricular activities (52.6%), research (50.9%), class rank (49.3%), and AOA (46.5%).

Students in the clinical years of training were more likely to place importance on honors grades ($p=0.04$) and AOA ($p=0.009$) and were less likely to place importance on grades in fourth year electives not in their chosen specialty ($p<0.0001$), scores on USMLE Step 1 ($p=0.0003$), USMLE Step 2 ($p<0.0001$), and Dean's letter ($p<0.0001$).

The authors concluded that misperceptions about which criteria are important in residency selection are common among medical students. Many overestimate the importance of subjective criteria while undervaluing objective criteria.

**http://www.med-ed-online.org/volume10.htm#Res00138**

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## Small Reduction in HbA1C Has Large Affect on Complications

Each 1% reduction in updated mean HbA1C was associated with reductions in risk of 21% for any end point related to diabetes, according to the The UK prospective diabetes study (UKPDS).

Both the observational and clinical trial analyses of an intensive glucose control policy suggest that even a modest reduction in glycemia has the potential to prevent deaths from complications related to diabetes as cardiovascular and cerebrovascular disease account for 50-60% of all mortality in this and other diabetic populations. Individuals with very high concentrations of glycemia would be most likely to benefit from reduction of glycemia as they are particularly at risk from the complications of type 2 diabetes, but the data suggest that any improvement in glycemic control across the diabetic range is likely to reduce the risk of diabetic complications.

**http://bmj.bmjjournals.com/cgi/content/full/321/7258/405**

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## Treating Glaucoma Early Lowers Economic Burden

Treatments that delay the progression of glaucoma may significantly reduce the economic health burden on people with the disease and on the U.S. health system, according to a new study by researchers at Duke University Eye Center and elsewhere. Their findings appear in the January 9, 2006, issue of Archives of Ophthalmology.

The team determined that patients with early-stage or suspected glaucoma use approximately $623 per year in health care resources, while patients with end-stage disease consume approximately $2,511. The cost of medication was responsible for one-third to half of the total direct cost to consumers.

**http://www.dukemednews.org/news/article.php?id=9441**

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## Warming Device Provides Relief

Eyefeel, a warming device by Kao Inc., used four times daily provded relief of post-LASIK dryness, according to Researchers at Miami's Ocular Surface Center. They reported that persistent dry eye after LASIK can be attributed to in part to delayed tear clearance, undercorrected aqueous tear deficiency, and nonrecognized lipid tear deficiency. They also reported that an eye-warming device may offer symptomatic relief in such cases.

**http://www.revophth.com/index.asp?page=1_807.htm**

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## STAR Estimates Glaucoma Risk

The Scoring Tool for Assessing Risk (STAR) is intended for use in patients with untreated ocular hypertension. It is a cardboard, slide rule-type device featuring two sliding bars (A and B) and three windows.

To use STAR, clinicians first need to gather the following six pieces of patient data:

- Current age
- IOP–averaged for both eyes from 2 to 4 visits over the preceding 6 months. (Data from a single visit will provide an estimate within 3% of calculated risk for 95% of patients.)
- Central corneal thickness (CCT)–averaged from three measurements obtained from both eyes at a single visit
- Pattern standard deviation (PSD)–average of both eyes from the most recent visual field index report
- Vertical cup/disc (C/D) ratio–average for both eyes
- Diagnosis of diabetes mellitus

With that information in hand, the clinician first pulls bar A to match the patient's age with the IOP in the upper window of STAR. Then, leaving bar A alone, bar B is pulled to match the PSD and CCT values in the middle window. Finally, the vertical C/D ratio value is identified according to whether the patient does or does not have diabetes, and then the clinician reads out the estimated 5-year risk of developing glaucoma in the bottom window relative to the patient's vertical C/D ratio. Risk is reported in ranges of 1% to 5%, 6% to 10%, 11% to 15%, 16% to 20%, 21% to 30%, 31% to 40%, 41% to 50%, and >50%.

**http://www.ophthalmologytimes.com/ophthalmologytimes/article/articleDetail.jsp?id=261841**

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## Smoking and Passive Smoke Increases AMD Risk

Smoking a packet of 20 cigarettes a day for more than 40 years tripled the risk of developing AMD compared with non-smokers, according to John Yates, a medical geneticist from Cambridge University. Passive smokers, defined as those who had lived with someone who smokes for five years or more, were found to double their risk. There was no difference between men and women. Stopping smoking appears to reduce the risk of developing AMD.

**http://bjo.bmjjournals.com/cgi/content/full/90/1/75**

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## Rated #2 for Excellent Careers in 2006

Rated just behind Audiologists, optometrist has been selected number 2 of Excellent Careers in 2006.

**http://www.usnews.com/usnews/biztech/articles/060105/5bestcareers.htm**

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## New Diabetic CPT Codes

The main ICD-9 revisions for 2005 that pertain to ophthalmology involve the changes made in coding diabetic. New ICD-9 codes are to be used for dates of service after October 1, 2005. Be sure the visit did not occur before that date or the claim will be denied.

ICD-9 codes:

362.03 Nonproliferative diabetic
retinopathy, NOS
362.04 Mild nonproliferative
diabetic retinopathy
362.05 Moderate nonproliferative diabetic retinopathy
362.06 Severe nonproliferative diabetic retinopathy
362.07 Diabetic macular edema

**http://www.eyeworld.org/article.php?sid=2929**

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## Some Carriers Pay for Second Visual Field

One area of Medicare audits involves billing for visual fields. There are three codes related to this procedure: 92081, 92082, and 92093. Only 92083 is threshold and the one usually used for glaucoma patients. When performing visual fields prior to blepharoplasty, you must use either the 92081 or 92092 codes. Since this procedure is usually performed twice (taped and untaped), the questions becomes whether the second visual field can be bill. Occasionally you come across a carrier that will pay for two sets. These carrier instructions state to use modifier -76 on the second set of visual fields.

**http://www.eyeworld.org/article.php?sid=2835**

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## Help Keep Us Informed

Please don't hesitate to submit news and notes to the Optimum VA. The more you submit, the better our newsletter will be. Such information may include:

- Letters to the editor
- Case reports
- Photos
- Article abstracts (include publication information)
- Upcoming events (CE, meetings, etc.)
- Personal accomplishments
- Internet links

*** Feel free to submit at any time by clicking the link Contact Optimum VA which is also located on the front page in the Editor's Box. Submission and publication dates are listed below.**

**** Residents and students are also encouraged to submit.**

| Issue | Submissions Due | Publication Date |
|---|---|---|
| **Winter** | **December 15** | **January 1** |
| **Spring** | **March 15** | **April 1** |
| **Summer** | **June 15** | **July 1** |
| **Fall** | **September 15** | **October 1** |

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## Associations, Institutes, Organizations, Societies

All About Vision
Alliance for Aging Research
American Academy of Ophthalmology
American Academy of Optometry
American Academy of Pediatrics
American Optometric Association
American Optometric Foundation
Association of Regulatory Boards of Optometry (ARBO)
Council for Refractive Surgery Quality Assurance
Eye Advisory
Eye Surgery Education Council

Glaucoma Research Foundation
Healthy Vision 2010
International Glaucoma Association
NASA Vision Group
National Eye Research Foundation
National Keratoconus Foundation
National Optometric Association
NBEO
Optometric Extension Program
Optometric Refractive Surgery Society
Optometrists.org
ORMS
Parents Active for Vision Education
RGP Institute
Schepens Eye Research Institute
Vision Council of America
World Council of Optometry

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## Coding

AHIMA
AMA (CPT)
Centers for Medicare & Medicaid Services
Healthcare Common Procedure Coding System (HCPCS)
ICD-9-CM Coordination and Maintenance Committee
NCHS - Classification of Diseases , Functioning, and Disability
Medicare Carriers By State

- Alabama
- Alaska
- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- District of Columbia
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana

Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri (Eastern)
Missouri (Western)
Montana
Nevada
New England
New Hampshire
New Jersey
New Mexico
New York
New York (Queens County)
New York (Upstate)
North Carolina
North Dakota
Ohio
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## Contact Lens

Acuvue
Bausch & Lomb
British Contact Lens Association
CIBA Vision NIGHT & DAY
CIBA Wesley-Jessen
Contact Lens and Anterior Eye
Contact Lens Council
Contact Lens Manufacturers Association

Contact Lens Spectrum
CooperVision
Innovative Sclerals Ltd.
International Association of Contact Lens Educators (IACLE)
New Zealand Contact Lens Society
Ocular Sciences
Official Site of Silicone Hydrogel Lenses
Virtual Consultant

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## Conventions and Meetings

Great Western Council of Optometry
Heart of America Contact Lens Society
Midwest Vision Congress & Expo
OptoEast
OptoWest
Southern Council of Optometrists
Vision Expo East
Vision Expo West

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## Foreign Web Sites

American Academy of Optometry (British Chapter)
Association of Optometrists, UK
Australasian College of Behavioural Optometrists (ACBO)
Bradford, University of, Department of Optometry (UK)
Brazilian Optometry Association
Canadian Association of Optometrists
College of Optometrists - UK
Eye Health Council of Canada
Hong Kong Polytechnic University Optometry Section (PRC)
Hong Kong Society of Professional Optometrists
Institute of Optometry - UK
Karolinska Institue - Sweden
Melbourne College of Optometry - Australia
New Zealand Association of Optometrists
Ontario Association of Optometrists
Optometrists Association (Victoria)
Optometrists Association Australia (New South Wales Division)
Optometrists Association Australia (Queensland Division)
Optometrists Association Australia (Victorian Division)
Optometry and Optics Today - UK
Tanzania Optometric Association

Thai Optometry
Victorian College of Optometry

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## Government Health

Armed Forces Optometric Society
Centers for Disease Control and Prevention
ClinicalTrials.gov
Federal Registry
NAVAO
VA Optometry

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## Journals

American Journal of Ophthalmology
American Society of Cataract and Refractive Surgery
Archives of Ophthalmology
British Journal of Ophthalmology
Digital Journal of Ophthalmology
Eyeworld
Ocular Surgery News
Ophthalmology Times
Ophthalmology
Primary Care Optometry News
Primary Eye Care News
Review of Ophthalmology
Review of Optometry

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## Low Vision and Vision Therapy

American Foundation for the Blind
Canadian National Institute for the Blind
Eschenbach Optical
Foundation for Fighting Blindness
Lighthouse International
Low Vision Gateway
NORA - Neuro-Optometric Rehabilitation Association
Ocutech
Prevent Blindness America
State License Renewal Requirements

Vision and Computers

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## Ocular Disease

AMD Alliance International
American Macular Degeneration Foundation
Lutein Information
Macular Degeneration Foundation
Macular Degeneration International
Macular Degeneration Network
Macular Degeneration Partnership
Macular Disease Society
MAXIVISION
Center for Keratoconus
Chua Eye Page
Collaborative Longitudinal Evaluation of Keratoconus Study (CLEK)
EyeCancer Network
Ophthoguide
Ophtholinx
Trials Summary

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Alcon Laboratories
Allergan
BOTOX®
Carl Zeiss Meditec
Hilco
Lombart Instruments
Medtronic Solan
Merck
Novartis Ophthalmics
Novartis
Reichert Ophthalmic Instruments
Reliance Medical Products
Topcon
Wilson Ophthalmic
Zeiss HSO-10 Bulb Lombart Instrument Company

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## Optical

Corning Ophthalmic
Essilor
General Optical Council - UK
National Academy of Opticianry
Optical Laboratories Association
Optical Society of America
Opticians Association of America
Opticians Association
Polycarbonate Lens Council
Prio
SOLA
Varilux

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## Optometry Schools

Illinois College Of Optometry
Indiana University
Michigan College of Optometry at Ferris State University
New England College of Optometry
Northeastern State University
NSU College of Optometry
Ohio State University
Pacific University
Pennsylvania College of Optometry
Southern California College of Optometry
Southern College of Optometry
SUNY State College of Optometry
UAB School of Optometry
University of California - Berkeley
University of Houston
University of Missouri - St. Louis

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## State Optometry Associations

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Maine
Maryland
Massachusetts
Michigan
Minnesota
Missouri
Montana
Nebraska
Nevada
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New Jersey
New York
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## Systemic Disease

American Diabetes Association
AskPhysicians.com
National Headache Foundation
Sjögrens Syndrome Foundation

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