



**SECTION II : CERTIFICATION OF EDUCATION**

**INSTRUCTIONS TO INSTITUTION:** Please complete: 1. Either Part A **or** Part B as appropriate; AND  
2. Part C

Please sign and date the certification and return this form directly to the Office of the Professions at the address shown below. **DO NOT RETURN THIS FORM TO THE APPLICANT.**

**PART A – REGISTERED/ACCREDITED PROGRAMS**

To be completed by those schools whose ophthalmic dispensing program is, or was at time the degree was awarded:

- Registered by the New York State Education Department as licensure qualifying,  
OR
- Accredited by the Commission on Opticianry Accreditation (COA).

It is hereby certified that: \_\_\_\_\_  
(Name of applicant)

has satisfactorily completed all requirements for the degree of \_\_\_\_\_  
(Title of degree)

whether or not the diploma has actually been awarded. Date all requirements for degree were met \_\_\_\_ / \_\_\_\_ / \_\_\_\_.  
mo. day yr.

**PART B – NON-APPROVED PROGRAMS**

**NOTE:** Please attach an official transcript (with dates of attendance, courses completed and grades), a syllabus of the course of study (if not previously submitted), and a list of clinical education completed (including required length).

To be completed by those schools whose ophthalmic dispensing program **is not, or was not**, at time the degree was awarded:

- Registered by the New York State Education Department as licensure qualifying,  
OR
- Accredited by the Commission on Opticianry Accreditation (COA).

It is hereby certified that: \_\_\_\_\_  
(Name of applicant)

was awarded the degree of \_\_\_\_\_ on the date of \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Title of degree) mo. day yr.

Date all requirements for degree were met \_\_\_\_ / \_\_\_\_ / \_\_\_\_.  
mo. day yr.

**PART C - CERTIFICATION:** Note: Certification is not acceptable unless dated and submitted after the applicant's graduation.

I hereby certify that to the best of my knowledge and belief the foregoing is a true statement of the education record of the individual named on this form.

Signature of Registrar or designee: \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mo. day yr.

Type or print name: \_\_\_\_\_

Title or official position: \_\_\_\_\_

**(INSTITUTION SEAL)**

Institution: \_\_\_\_\_

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

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

**Return Directly to:** New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Ophthalmic Dispensing Unit, 89 Washington Avenue, Albany, NY 12234-1000.