## Ophthalmic Dispensing Form 4

**The University of the State of New York**  
**THE STATE EDUCATION DEPARTMENT**  
**Office of the Professions**  
**Division of Professional Licensing Services**  
89 Washington Avenue  
Albany, NY 12234-1000

### CERTIFICATION OF TRAINEE EXPERIENCE IN OPTHALMIC DISPENSING AND/OR CONTACT LENS DISPENSING

**Applicant instructions**

1. Complete Section I in ink. Enter your name as it appears on your trainee permit. Be sure to sign and date item 5.
2. Send this form to your supervisor(s) for them to complete Section II then forward the form directly to the Office of the Professions at the address at the end of this form. A separate Form 4 (make copies as needed) should be submitted by each certifying supervisor.

   This form will not be accepted if submitted by the applicant

### SECTION I: TO BE COMPLETED BY THE TRAINEE

<table>
<thead>
<tr>
<th>1 Social Security Number</th>
<th>2 Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Leave this blank if you do not have a U.S. Social Security Number)</td>
<td>Month Day Year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3 Print Your Name Exactly As It Appears On Your Trainee Permit</th>
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</thead>
<tbody>
<tr>
<td>Last</td>
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<tr>
<th>4 Trainee Permit Number</th>
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| 5 I request and give my permission to the individual named below to complete Section II of this form and mail it to the New York State Education Department and to release any other information required by the State Education Department in connection with my application for licensure. |

Applicant's signature: ____________________________ Date: ______ / ______ / ______

### SECTION II: TO BE COMPLETED BY THE CERTIFYING SUPERVISOR

I certify that the applicant named above completed trainee experience in ophthalmic dispensing and/or contact lens dispensing while supervised by me as follows:

**Ophthalmic Dispensing Trainee Permit:**

Dates of supervision: from _____ / _____ / _____ to _____ / _____ / _____

**Contact Lens Dispensing Trainee Permit:**

Dates of supervision: from _____ / _____ / _____ to _____ / _____ / _____

**ATTESTATION**

I declare and attest that the above statements are a true, complete, and accurate record of the trainee experience of the applicant named on this form.

Signature of supervisor: ____________________________ Date: _____ / _____ / _____

Print name of supervisor: ____________________________

Profession of supervisor:  
[ ] Ophthalmic Dispensing  [ ] Optometry  [ ] Medicine

License number: ____________________________

Employing agency or institution: ____________________________

Address: ____________________________________________

Street: ____________________________    City: ____________________________    State: ____________________________    Zip code: ____________________________

Phone: ____________________________    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.

Ophthalmic Dispensing Form 4, Rev. 12/04