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 OPHTHALMIC 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 you 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

1 Social Security Number ☐☐☐-☐☐-☐☐☐☐

(Leave this blank if you do not have a U.S. Social Security Number)

2 Birth Date ☐☐ ☐☐ ☐☐

Month Day Year

3 Print Your Name Exactly As It Appears On Your Trainee Permit

Last ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Middle ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

4 Trainee Permit Number ☐☐☐☐☐☐☐☐

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: _____ / _____ / _____
mo. day yr.

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* _____ / _____ / _____
mo. day yr. mo. day yr.

Contact Lens Dispensing Trainee Permit:

Dates of supervision: *from* _____ / _____ / _____ *to* _____ / _____ / _____
mo. day yr. mo. day yr.

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.