Ophthalmic Dispensing Form 4
Certification of Trainee Experience in Ophthalmic Dispensing and/or Contact Lens Dispensing

The University of the State of New York
The State Education Department
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Applicant Instructions

1. Complete Section I. In item 3, enter your name exactly as it appears on your Application for Trainee Permit (Form 5T). Be sure to sign and date item 5.
2. Send this form to your supervisor(s) and ask them to complete Section II and forward the form directly to the Office of the Professions at the address at the end of this form. A separate Form 4 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 ☐☐☐☐☐☐☐☐☐ 2. Birth Date Month ☐☐ Day ☐☐ Year ☐☐☐☐

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

3. Print Your Name Exactly As It Appears On Your Application for Trainee Permit (Form 5T)

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 _____

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 ____ ____ ____ (mo. day yr.) to ____ ____ ____ (mo. day yr.) Total number of clock hours supervised _____

*A traineeship of at least 2 years and 2,400 clock hours is required (Regulations of the Commissioner Part 67)

Contact Lens Dispensing Trainee Permit**

Dates of supervision: from ____ ____ ____ (mo. day yr.) to ____ ____ ____ (mo. day yr.) Total number of clock hours supervised _____

A traineeship of at least 1 year and 1,200 clock hours is required **in addition to the time listed above for an Ophthalmic Dispensing Trainee Permit (Regulations of the Commissioner Part 67)

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 _____

License Number _____

Employing Agency or Institution _____

Address _____

_____

Telephone _____ Fax _____ Email _____

Profession of Supervisor:

- ☐ Ophthalmic Dispensing
- ☐ Optometry
- ☐ Medicine

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.

Reset Form