	Arizona State Board of Optometry 1740 W. Adams St., Third Floor Phoenix, AZ 85007 Telephone (602) 542-8164 • Fax (602) 883-7253	OFFICE USE ONLY

STATE BOARD CERTIFICATION AND LICENSE VERIFICATION

ENDORSEMENT APPLICATION SUPPLEMENT

To be submitted directly to AZ State Board from your current licensing Board

TYPE or PRINT

THE_____OF_____
Name of Board State

LOCATED AT_____
Address City State Zip

I,_____, _____
Name Title

hereby certify that _____ _____ _____
Name of Applicant License No. Date of Issue

is and has been licensed to practice optometry for not less than four of the past five years in the State of_____ and

received certification to use: diagnostic (DPA), therapeutic/topical (TPA), oral pharmaceutical agents (PA) on _____
(Circle all that apply) **(date)**

and that the license and/or certificate and registrations are in good standing. Is the applicant known to you to have been licensed to

practice Optometry in any other state and, if yes, the name(s) of that state: _____ _____ _____
Yes No State(s)

State the basis for and result of any disciplinary action taken against the applicant within the preceding 10 years including

Censure_____ Probation_____ Suspension_____ Revocation_____Other_____

Are there any pending investigations or complaints regarding the applicant _____Yes _____No

If so, please describe:_____

_____

Given this _____ day of _____ 20____, under the seal and signature of _____
State Board/Agency

_____ , _____
Signature Title

OR: SWORN BEFORE ME THIS _____ DAY OF _____ 20____

_____
Notary Public

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Phoenix, AZ 85007
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ALL ENDORSEMENT APPLICANTS
PLEASE SUBMIT THIS FORM FOR VERIFICATION

Please Send this Letter to Your College Of Optometry

The following item must be submitted to complete your application. The Arizona State Board of Optometry conducts primary source verification of education, training, and national examination scores; therefore, verification documents must be mailed directly to the Board from these entities. All documentation must be sent to the Arizona State Board of Optometry, 1740 W. Adams St., Third Floor, Phoenix, AZ 85007.

Please note: The application cannot be approved until **ALL** documentation has been received from the applicant and the primary source verifying entities.

(College of Optometry: Please copy the following information on to your official letterhead)

_____ provided _____
Name of Institution Name of Doctor

with _____hours of transcript quality didactic education (must collectively equal at least 120 hours), pharmacology and clinical training in the examination, diagnosis, and treatment of conditions of the human eye and adnexa. With a minimum of 12 hours of pharmacologic principles in the side effects, adverse reactions, drug interactions, use of systemic antibiotics, analgesics, antipyretics, antihistamines, over-the-counter medications, and medications and procedures to counter the affect of adverse reactions.

The education was provided from _____ to _____ .
(Beginning date) (Ending date)

How many of the above hours are equivalent to the education received by an August 6, 1999 graduate of your Institution? _____.

Signature and title of School Representative: _____

Date: _____

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