

**Douglas A. Ducey**  
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Vice President



**Arizona State Board of Optometry**

1400 West Washington, Suite 230

Phoenix, AZ 85007

**Margaret Whelan**  
Executive Director

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Telephone (602) 542-8155 • Fax (602) 542-3093

**APPLICATION FOR  
VOLUNTEER HEALTH SERVICES REGISTRATION**

Print in blue or black ink. **You must provide a response to each question; if not applicable, please put N/A.**

1. This application is for an Optometrist Volunteer Registration? Yes: \_\_\_\_\_ No: \_\_\_\_\_
  
2. Legal name (Last, first, middle).  
\_\_\_\_\_
  
3. List other names or aliases, including maiden names.  
\_\_\_\_\_
  
4. Current mailing address:  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_
  
5. E-mail address: \_\_\_\_\_
  
6. Social Security Number (requirement pursuant to A.A.C. R4-21-201) \_\_\_\_\_
  
7. Date of Birth: \_\_\_\_\_
  
8. Optometry School \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Degree \_\_\_\_\_ Year graduated \_\_\_\_\_
  
9. List the state(s), territory and/or possession of the United States where you currently hold an active, unrestricted license to practice optometry. Please include the issue and expiration date of the license.  
\_\_\_\_\_  
\_\_\_\_\_

10. List the state(s) territory and/or, possession of the United States where you were previously licensed to practice optometry. If no previous license(s), indicate NONE.
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11. a. I certify that I hold an active and unrestricted Optometry license in a state, territory or possession of the United States.
- b. I certify I have never had an Optometry license revoked or suspended.
- c. I certify I am not the subject of an unresolved complaint.
- d. I agree to render services at a free medical clinic that does not provide abortions and restricts the optometrist's authorized services and duties to the provision of care or service at a free medical clinic.
- e. I will provide only the scope of optometric services for which I am licensed or authorized to provide by the regulatory agency of the state, territory or possession of the United States where I currently hold a license, even if the scope of practice in Arizona is higher than my current state of licensure's scope of practice.
- f. I hereby give my permission for the Arizona State Board of Optometry to secure additional information concerning this application from the applicable regulatory agency of each state where I am licensed or have held a license.
- g. I understand if volunteer registration is issued, I may practice in Arizona for up to fourteen (14) days each calendar year.
- h. I understand if volunteer registration is issued, the registration period is for two years from the issue date.
- i. I certify that I have read and answered all the questions on this application.
12. I, \_\_\_\_\_, the applicant herein, state and depose that all facts, statements and answers outlined in this application are true and correct; that I am not omitting any information which might be of value to this Board in determining my qualifications and I agree that any falsification, omission, or withholding of information of facts concerning my qualifications as an applicant shall be sufficient to deny me a volunteer health services registration and that, pursuant to A.R.S. §32-1743, withholding such information shall serve as sufficient grounds for the revocation, cancellation, or suspension of my volunteer health services registration in optometry if it is not discovered until after issuance.

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Signature of Applicant

STATE OF \_\_\_\_\_

County of \_\_\_\_\_

SUBSCRIBED AND SWORN TO before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

My Commission Expires:

\_\_\_\_\_  
Notary Public