Secretary of State
Office of Professional Regulation

OPTICIANS
Affidavit of Registered Optician Training (traineeship)

To be completed by the Applicant:

Applicant's Name:			
Address:			
Phone No.:		Email:	
Applicant's Signature			

To be completed by the Ophthalmologist, Optometrist, or Optician verifying the above-mentioned Applicant's training:

Practice Name:			
Practice Address:			
Supervisor Name:		Title (OD, MD, etc.)	

Based on your personal knowledge of the above-named applicant:		
How long (months/years) have you known the applicant?	Months _____	Years _____
When did he or she begin practicing as an optician trainee under your supervision?	Date as MM/YY	
Indicate the number of hours the applicant worked per year	Hours Per Year	

Indicate states in which you are currently licensed		Your VT License No.	

Signature of Supervisor

I certify, under the pains and penalties of perjury, that all information I have provided in this application is true and accurate. I understand that furnishing false information may constitute unprofessional conduct and result in the denial of my application or further disciplinary action. The maximum penalty for perjury is fifteen years in prison and/or a $10,000 fine. (13 V.S.A. §2901)	
Signature of Supervisor	Date