Secretary of State

Office of Professional Regulation

OPTICIAN TRAINEE

Notification of Supervision

To be completed by the Trainee (Applicant):

Applicant's Name	
Applicant's DOB	
Name of Practice	
Applicants Signature	

The following must be completed by the Ophthalmologist, Optometrist or Optician supervising the above trainee:

Name if Supervisor		Title:	
VT License #		Date of Initial Licensure	
Name of Practice:			
Address of Practice:		Phone #:	
Training will begin on: ______________________________			

List below any other Optician Trainee you are currently supervising

Trainees Name:	Trainees Registration Number:

STATEMENT OF SUPERVISOR OF RECORD

I acknowledge that I am responsible for the above-named trainee licensee during the period of temporary licensure. I certify that the above statements are true and accurate to the best of my knowledge.

______________________________ ______________________________

Signature of Supervisor of Record **Date**