Secretary of State

Office of Professional Regulation

OPTOMETRIST

Verification of Experience

To be completed by the applicant:

Applicant's Name:			
Name of Practice:		Email:	
Address of Practice:	Street/Apt. #, or PO Box:		
	City/State/Zip:		

I hereby certify that the information above is an accurate account of work I perform, and that I have actively practiced clinical Optometry medicine for 3,000 hours within the last three years preceding my application to Vermont.			
Signature:		Date:	

To be completed by the Optometrist or Ophthalmologist verifying the above information:

1. How long (months/years) have you known the applicant?		Dates: From/to	
2. When did he or she begin practicing as an Optometrist (month/year)?			
3. Has the applicant been actively engaged in the licensed practice of optometry for at least 500 hours during each of the two years immediately preceding his/her application for licensure in the State of Vermont?	Yes	No	
	If No, please explain:		
Print name of Optometrist of Ophthalmologist verifying this information.			
Address:	Street/Apt. #, or PO Box:		
	City/State/Zip:		
Daytime Phone:		Email:	
State(s) in which you are currently licensed and practicing:		License Number(s):	

I hereby certify that the above statements are true and accurate to the best of my knowledge.			
Signature:		Date:	