Government of the District of Columbia
Department of Health
Health Professional Licensing Administration

BOARD OF OPTOMETRY

Request for Verification of State Licensure

Name of Applicant _____

Social Security Number _____

License Number _____

Dear Sir/Madam:

The applicant whose name appears above has applied to the Board of Optometry of the District of Columbia for a license to practice Optometry. The applicant claims to be currently licensed to practice Optometry in your state and claims the above license number. This request is being forwarded to you to verify that the applicant is currently licensed and is in good standing to practice Optometry in your state.

Please complete and return this form to:

DC Board of Optometry
P.O. Box 37802
Washington, D.C. 20013

Your prompt attention to this request will expedite consideration of the candidate's application for licensure. Thank you in advance for your cooperation.

Verification of State Licensure in Optometry

This document certifies that _____(name of applicant) is the holder of a license in good standing to Optometry in the state of _____.

License Number _____was issued on _____(date of issuance).

Is the license current? ☐ Yes ☐ No

Please provide the expiration date: _____

Issue basis: ☐ Examination ☐ Endorsement ☐ Reciprocity ☐Waiver

Applicant was examined after submitting a diploma conferring the degree of _____(type of degree) from _____(name of education institution).

Has license ever been surrendered, suspended, or revoked? ☐ Yes ☐ No

If yes, has it been reinstated? ☐ Yes ☐ No (Please give full particulars on the reverse side of this form.)

Has applicant taken and passed the national examination in Optometry? ☐ Yes ☐ No If yes, what year? _____

Does your state grant licenses in Optometry to licensees from the District of Columbia without further examination? ☐ Yes ☐ No

Remarks: _____

_____

_____

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_____

_____

_____

On behalf of the State of _____Board of Optometry, I certify that the above statements are correct.

_____ _____

Signature of Authorized Official Date

_____

Name and Title of Authorized Official (please print or type)

(SEAL)