



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF EXAMINERS IN OPTOMETRY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

VERIFICATION OF OPTOMETRIST LICENSE

Send a separate form to *each* jurisdiction other than Delaware where you have ever held a license to practice Optometry.

Licensing Authority: _____		Applicant Name: _____	
Address: _____		Home Address: _____	
City/State/Zip: _____		City/State/Zip: _____	
This section is to be completed by applicant.	Last Name: _____ First: _____ Middle: _____		
	SSN: _____ DOB: _____		
	Other Name(s) Used: _____		
	License Number(s) in Jurisdiction Named Above: _____		
	<p>I am applying for licensure as a Therapeutic Optometrist in the State of Delaware. Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the Delaware Board of Examiners in Optometry .</p>		
Applicant Signature: _____		Date: _____	
This section to be completed by Licensing Authority	Our records indicate that the applicant named above was licensed in the State/Province/Jurisdiction of _____		
	License Number: _____		
	Issue Date (mm/dd/yyyy): _____ Expiration Date (mm/dd/yyyy): _____		
Has any discipline activity taken place regarding this licensee? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please enclose a certified copy of the Board Order with this license verification.			
CERTIFICATION AFFIX OFFICIAL SEAL HERE	Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.		
	Printed Name of Official: _____		
	Signature of Official: _____		Date: _____
	Title: _____		
	Phone: _____	Fax: _____	Email: _____

Mail (do not fax) completed, signed and sealed form *directly* to the Board office at the address above.