



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

STATE OF DELAWARE
BOARD OF EXAMINERS IN OPTOMETRY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@delaware.gov

VERIFICATION OF OPTOMETRIST LICENSE

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

Enter your Application ID: _____

Licensing Authority: _____ Address: _____ City/State/Zip: _____	Applicant Name: _____ Home Address: _____ City/State/Zip: _____
Applicant completes this section	Last Name: _____ First: _____ Middle: _____ SSN: _____ Date of Birth: _____ 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: _____
Licensing authority completes this section	Our records indicate that the applicant named above was licensed in the State/Province/Jurisdiction of _____ License Number: _____ Issue Date (month/day/year): _____ Expiration Date : _____ (month/day/year) _____ Has any discipline activity taken place regarding this licensee? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, enclose a certified copy of the Board Order with this license verification.
AFFIX OFFICIAL SEAL HERE	I certify that the information above is an accurate account of this person'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.