



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
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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 an optometry license.

Licensing Authority: _____		Applicant Name: _____	
Address: _____		Home Address: _____	
City/State/Zip: _____		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: _____		
	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 .		
AFFIX OFFICIAL SEAL HERE		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.		
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.