Optometry Form 4A

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

SUPPORTING AFFIDAVIT OF PROFESSIONAL PRACTICE

- FOR ENDORSEMENT APPLICANTS -

APPLICANT INSTRUCTIONS

1. Complete Section I in ink. Enter your name as it appears on your Licensure Application (Form 1). Be sure to sign and date item 7.

2. Send both pages of this form to the licensed optometrist(s) who will attest to your professional practice for completion of Section II and the certification.

Section I: Applicant Information

1 **Social Security Number** ☐☐☐-☐☐-☐☐☐☐

(Leave this blank if you do not have a U.S. Social Security Number)

2 **Birth Date** ☐☐ ☐☐ ☐☐
Month Day Year

3 **Print Name Exactly As It Appears On Your Licensure Application (Form 1)**

Last ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Middle ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

4 **Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Line 2 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Line 3 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

State ☐☐ Zip Code ☐☐☐☐☐ ☐☐☐☐

Country/ Province ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

5 Date of Licensure: _____ / _____ / _____
mo. day yr.

In which jurisdiction? _____

6 Name of practice: _____

Practice address: _____

Exact Dates of practice: From: _____ / _____ / _____ To: _____ / _____ / _____
mo. day yr. mo. day yr.

Licensed optometrist to which this form is being sent: _____

7 I request and give my permission to the licensed optometrist listed in item 6 to complete Section II of this form, release any other information required by the State Education Department in connection with my application for licensure, and return this form directly to the State Education Department at the address at the end of this form.

_____ _____
Applicant's Signature Date

Section II : Verification Of Professional Practice (Please print all information.)

INSTRUCTIONS TO THE LICENSED OPTOMETRIST: Please complete this section and return both pages of this form **directly** to the Office of the Professions at the address at the end of this form. **This form will not be accepted if returned by the applicant.**

1. Name of the applicant: _____
   First *Middle* *Last*

2. Your professional relationship to the applicant: _____

3. Applicant was in practice: From: _____ / _____ / _____ to _____ / _____ / _____
   mo. *day* *yr.* *mo.* *day* *yr.*

4. Name and address of applicant's practice setting: _____

   _____

5. Describe applicant's optometry practice experience: _____

   _____

   _____

   _____

   _____

   _____

   _____

6. Do you know the applicant to be of good moral character, and recommend the applicant to the Department as entirely worthy to be licensed to practice optometry in the State of New York? ☐ Yes ☐ No

   If "no", please explain on a separate sheet.

7. Other comments: _____

   _____

   _____

   _____

CERTIFICATION

I hereby certify that to the best of my knowledge and belief the foregoing is a true statement of the professional experience of the applicant named above.

Signature: _____ Date: _____ / _____ / _____
mo. *day* *yr.*

Print or type name: _____

Professional Title: _____

Name of Practice: _____

Address: _____

Telephone: _____ Fax: _____

E-mail Address: _____

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Optometry Unit, 89 Washington Avenue, Albany, NY 12234-1000.