

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



Board of Optometry

SUPPLEMENTAL INFORMATIONAL
AND
SIGNED STATEMENT OF UNDERSTANDING

Please print in ink or type your name and address where requested below:

Name (Last, First, Middle Initial)

Address (Street, City, State, Zip Code)

1. Have you taken the National Board Examination? Yes No when: _____ score: _____
2. Have you contributed to the Optometry Literature? Yes No if so, please attach a bibliography.
3. Have you received any honors, awards or fellowships? Yes No if so, please list here _____
4. Have you received any special Optometry training, or do you have any special optometry skills. Yes No
If so, please indicate _____

I certify that I have read and fully understand the regulations and rules governing the practice of Optometry in the District of Columbia.

Signature

Return this form with your application to:

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