

DISPENSING EXPERIENCE AND FITTINGS FORM

- FOR:**
- Internationally educated professionals
 - Graduates of non-accredited Canadian programs



Please submit one form for each place of employment.

1. FULL LEGAL NAME

First Name: _____

Middle Name(s): _____

Surname: _____

2. PERSONAL CONTACT INFORMATION

Home Address: _____

City/Town: _____ Province/State: _____ Country: _____

Postal Code: _____ Telephone: _____ Email: _____

3. RECORD OF ACTUAL DISPENSING EXPERIENCE

(Laboratory hours are NOT eligible)

Are you self-employed? Yes No

Business Name: _____

Business Address: _____

City/Town: _____ Province/State: _____ Country: _____

Postal Code: _____ Telephone: _____ Email: _____

First Day Of Employment: _____ / _____ / _____ (Month/Day/Year)

Last Day Of Employment (Enter N/A if still employed) _____ / _____ / _____ (Month/Day/Year)

Hours per week of actual dispensing _____

Total actual dispensing hours at the above location _____

4. RECORD OF EYEGLASSES AND CONTACT LENS FITTINGS

Number of eyeglass fittings

Multi focal _____ High myopic _____ Hyperopic _____

Number of contact lens fittings

Soft _____ Rigid Gas Permeable _____

5. DECLARATION OF SUPERVISOR *(Please print)*

I, _____, state that the above information is true to the best of my knowledge and belief and that _____ received the above actual dispensing hours during the specified period and/or number of eyeglasses and contact lens fittings under my supervision.

Date: _____ Signature of Supervisor: _____