Washington State Department of Health
Dispensing Optician Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Dispensing Optician Apprentice Training Certification

Note: Use this form to **document total apprenticeship training hours** when the apprenticeship supervision has terminated.

Please Print Clearly

Supervisor's Full Name _____
Last First Middle Initial

Business Name _____

Business Address _____

City _____ State _____ Zip Code _____ County _____

Daytime Telephone Number _____ License Number_____

Licensed to practice as: ☐ Physician ☐ Optometrist ☐ Dispensing Optician

I certify _____, has been under my direct supervision as an
Apprentice's Name

Apprentice Dispensing Optician for the period:

beginning _____ and ending _____
mm/dd/yyyy mm/dd/yyyy

and has accrued a total of_____ apprenticeship hours while under my supervision.

I,_____, certify I am the person identified above
Print Full Name of Direct Supervisor

as the supervisor and to the best of my knowledge and belief the statements made in this affidavit are true and correct.

Please remove this apprentice from my license. ☐ Yes ☐ No

Signature _____ Date _____