Dispensing Optician Apprentice
Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Approved Supervisor Statement

Applicant Demographics:			
First Name	Middle		Last Name
Credential # (If available)		Date of Birth	

Supervisor's Statement (must be completed by the supervisor)	
Supervisor Name	License Number

I certify that I am qualified to act as an apprentice dispensing optician supervisor and I have read and am familiar with Chapter 18.34 RCW and Chapter 246-824 WAC relating to the training and registration of apprentice dispensing opticians. I understand that direct supervision requires a supervisor to provide the majority of the training and be on the premises 80 percent of the time while the apprentice dispenses spectacles and 100 percent of the time while the apprentice adjusts and fits contact lenses. I will record the beginning and ending dates of supervision of this apprentice and maintain a record of total hours worked under my supervision. I understand that I may not have more than two apprentices under my supervision at any one time.

Signature of Supervisor ______________________________ Date ______________