

DISPENSING EXPERIENCE & FITTINGS FORM
(Please complete one form for each place of employment, if applicable;
Make copies of this form, as needed)

FULL LEGAL NAME OF APPLICANT	SURNAME:	
	FIRST NAME:	
	MIDDLE NAME(S):	
HOME ADDRESS:		
CITY/TOWN:		PROVINCE/STATE:
POSTAL CODE:		COUNTRY:
TELEPHONE # ()		E-mail:
RECORD OF ACTUAL DISPENSING EXPERIENCE (NB: LABORATORY HOURS ARE NOT ELIGIBLE)		
BUSINESS NAME:		SELF-EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO
BUSINESS ADDRESS:		
CITY:		PROVINCE:
POSTAL CODE:		COUNTRY:
TELEPHONE # ()		E-MAIL:
FIRST DAY OF EMPLOYMENT (DD/MM/YY):		LAST DAY OF EMPLOYMENT (DD/MM/YY) (enter "N/A" if still employed):
HOURS PER WEEK OF ACTUAL DISPENSING:		TOTAL ACTUAL DISPENSING HOURS AT THE ABOVE MENTIONED LOCATION:
RECORD OF EYE GLASSES AND CONTACT LENS FITTINGS		
NUMBER OF EYE GLASSES FITTINGS:		NUMBER OF CONTACT LENS FITTINGS:
[] MULTI FOCAL		[] SOFT
[] HIGH MYOPIC		[] RIGID GAS PERMEABLE
[] HYPEROPIC		

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 eye glasses and contact lens fittings under my supervision.	
Date:	Signature of Supervisor: