Washington State Department of HEALTH

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

Experience Certification

Applicant Instructions

A separate copy of this form should be used to certify each position listed as work experience outside of Washington State. It is the applicant's responsibility to have this form fully completed by their previous employer. This form should be submitted to the above address by each previous employer.

Section I - To Be Completed by the Applicant

Full name under which you are applying

Previous or other name(s) used

Street address

City | State | Zip | Phone number (ten digit)

Signature of Applicant

Section II - To Be Completed by the Employer

I certify the applicant named above was employed for a period of _____ months

from _____ to _____ by:

Name of Firm or Agency

Street address

City | State | Zip Code

Applicant's Job Title:

Detailed description of optician duties performed by the applicant:

The applicant was actually and primarily engaged in the practice of dispensing optician. Under penalties of perjury, I declare and affirm the above statements are true, complete and correct.

Signature of Employer/Authorized Agent _____

Position in Firm _____ Date _____

Address _____