



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 applying _____

Previous or other name(s) used _____

Street Address _____

City _____ State _____ Zip Code _____ Phone (enter 10 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 _____

The applicant was actually and primarily engaged in the practice of a 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 _____