



Washington State Department of  
**Health**

Optometry Credentialing  
P.O. Box 47877  
Olympia, WA 98504-7877  
360-236-4700

## Letter of Recommendation

Please complete this reference form and return it directly to the address shown above.

This is to certify I have known \_\_\_\_\_

for \_\_\_\_\_ years, from \_\_\_\_\_ to \_\_\_\_\_, during which period he/she was engaged in the study or active practice of optometry. To the best of my knowledge he/she is of good moral and professional character, is free from habits which might interfere with his/her professional activities and is worthy of holding a license to practice optometry in the state of Washington.

**Additional Comments:**

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**Note:** No member of the profession is expected to sign this recommendation who does not know the applicant personally or who is not willing to supply additional information concerning this person's character, standing and education, upon request from Health Professional Quality Assurance.

Print your name

Your Signature

Address

City

State

Zip Code

Phone (enter 10 digit #

Licensed under the laws of \_\_\_\_\_ to practice Optometry.  
Name of State