Washington State Department of
Health
Ocularist Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360-236-4700

Training Certification

Please Print Clearly

Supervisor's Full Name _____
<div align="center">Last Name   First Name   Middle Initial</div>

Business Name _____

Business Address_____
<div align="center">City   State Zip Code County</div>

Daytime Phone (enter 10 digit #) _____

Licensed to practice as_____

License Number _____

I certify that (Apprentice's Name) _____
has been under my direct supervision as an Apprentice Ocularist for the period beginning:

Month _____ , Day _____ ,Year _____and ending:

Month _____ , Day _____ ,Year _____and has accrued a total of _____
apprenticeship hours while under my supervision.

I, _____, certify that I am the person
<div align="center">Print Full Name of Direct Supervisor</div>
identified above as the supervisor and that to the best of my knowledge and belief the statements made in this affidavit are true and correct.

Signature_____

Date _____

DOH 678-005 August 2016