

**LICENSE OF RECORD - REQUEST FOR INFORMATION FROM DISPENSARY- YEAR**

I \_\_\_\_\_ am the owner/manager/license of record  
 (Print name and license number) (Circle one, both or all)

of \_\_\_\_\_  
 (Name of dispensary)

located at \_\_\_\_\_  
 (Complete address)

**Please list all Licensed Opticians and Contact Lens Licensed Opticians employed at this location**

Full name (please print)	License Number	Active License (Yes/No)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**What services are provided at the dispensary (Please check all that apply):**

- Eyeglass dispensing
- Contact lens fitting
- Contact lens dispensing
- Sight testing

**Please attach your policy and/or procedures that apply when there is no Licensed Optician or Contact Lens Licensed Optician on the premises.**

**Please provide the hours that this location is open/closed:**

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open							
Closed							

