



Board of Examiners in Optometry
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REQUEST FOR LICENSE VERIFICATION- APPENDIX C

Must be completed by the regulatory agency of any other state in which you have been licensed. States may also use their own forms.

Applicant Name: License Number:

Issue Date: Expiration Date:

Current License Status: Active [] Inactive [] Expired [] Revoked [] Probation [] Other []

Is this individual considered to be in good standing in your state? Yes [] No []

If no, please explain:

Has this license ever been revoked, suspended, restricted, limited, or placed on probation? Yes [] No []

If yes, please explain:

Is this individual currently under investigation or charged with a violation? Yes [] No []

If yes, please explain:

Was this individual required to pass a written examination at the time of initial licensure? Yes [] No []

Has this individual either passed the TMOD portion of the National Board of Examiners exam or have therapeutic pharmaceutical privileges? Yes [] No []

If no, please explain:

If this license is not in good standing or has ever been revoked, suspended, restricted, limited, or placed on probation, please provide a copy of the final order or other documentation of action taken.

FORM COMPLETED BY:

Name (Printed):
Signature:
Title:
State Agency:
Date:

