THE STATE of ALASKA

Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing

DOP

FOR DIVISION USE ONLY

Dispensing Opticians Program
PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550
Email: *DispensingOpticians@Alaska.Gov*
Website: *ProfessionalLicense.Alaska.Gov/DispensingOpticians*

Supervisor Statement of Responsibility

This form must be completed and signed by the licensed physician, optometrist, or dispensing optician who will provide the training and supervision of the hours obtained in dispensing optician's duties. The primary or alternate sponsor must submit this form directly to the letterhead address. Do not return it to the applicant.

PART I Payment of Fees

Sponsor Type:	☐ New Sponsor	**$ 0.00**
	☐ Change Sponsor *(Apprentice Verification of Training form (#08-4151b) also required)*	**$50.00**
	☐ Alternate Sponsor *(If the apprentice already has a sponsor.)* Primary Sponsor Name: _____ License Number: _____ License Type: _____	**$ 0.00**

PART II Sponsor Information

Apprentice Name:			
Sponsor Type:	☐ Primary ☐ Alternate	**Training Type:**	☐ Spectacles ☐ Contacts ☐ Both
Sponsor Name:			
Full Address:	P.O. Box or Street City State Zip		
Email Address:		**Contact Phone:**	
Alaska License Number:		**Expiration Date:**	
License Type:	☐ Optometrist ☐ Physician ☐ Dispensing Optician with an endorsement to dispense: ☐ Spectacles ☐ Contacts		

PART III Employer Information

Employer Name:				
Facility Name:				
Facility Address:	Street	City	State	Zip

PART IV Notarized Signature

I hereby certify that I will provide regular supervision of this apprentice within the scope of practice authorized by my license and will work at the same facility for the same employer as the apprentice. I will provide an alternate supervisor who may provide supervision to this apprentice when I am unavailable. I acknowledge I can have no more than two apprentices registered under my supervision.

I further acknowledge that I am responsible for the proper performance of any dispensing optician task that I delegate to the apprentice. I will notify the Dispensing Opticians Section within 30 days of the termination of my supervision. I understand that I will be asked to certify the apprentice's training and competency at the end of my supervision.

I certify under penalty of perjury that the above information is true and correct.

Notary Stamp	**Sponsor Printed Name:**			
	Sponsor Signature:			
	Notary Public for State of:		**Subscribed and Sworn to Before me on this Day:**	
	Notary Signature:		**My Commission Expires:**	

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Credit Card Payment Form

All major credit cards are accepted. For security purposes, do not email credit card information. Include this credit card payment form with your application.

Name of Applicant or Licensee: _____

Profession Type (e.g., Acupuncture):

License Number *(if applicable)*: _____

I wish to make payment by credit card for the following *(check all that apply)*: **AMOUNT**

- ☐ Application Fee: _____ _____
- ☐ License or Renewal Fee: _____ _____
- ☐ Other *(fine, exam, etc.)*: _____ _____

1. _____ _____
2. _____ _____

TOTAL: _____

Name *(as shown on credit card)*: _____

Mailing Address: _____

Phone Number: _____ Email *(optional)*: _____

Signature of Credit Card Holder: X _____

08-4438 Rev 12/06/2022 Credit Card Payment Form (all major cards accepted)

CREDIT CARD INFO: Your payment cannot be processed unless all fields are completed!

1. Credit Card Number: -
2. Expiration Date: -
3. Security Code: -

All 3 fields **MUST** be completed!

This section will be destroyed after the payment is processed.