

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF OPTOMETRY

License Number
OB _____

BRANCH REACTIVATION APPLICATION

Name: _____
Address: _____
City: _____ State: _____
Zip: _____ Phone: _____
Email: _____

State Board of Optometry
PO Box 2649
Harrisburg, PA 17105-2649

License expired: _____

- YES, I have practiced at this location since it expired and I want to reactivate the branch at this time by paying the biennial renewal fee(s) and applicable late renewal fees. See table at the bottom for appropriate fees.**
- NO, I have not practiced at this location at any time since it expired and I want to reactivate the license at this time by paying the biennial renewal fee. See table at the bottom for appropriate fee.**

I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 PA C.S. 4911 and that any false statement made is subject to the penalties of 18 PA C.S. 4904 relating to unsworn falsification to authorities and may result in my license being disciplined.

Signature of Licensee (Mandatory): _____ Date: _____

<p align="center">Fees-PAYABLE TO COMMONWEALTH OF PA</p> <p>Practicing in PA after the license expired</p> <p>1. Submit renewal fee of \$20.00 plus late fees. 2. LATE FEE - \$5.00 per month, or part of a month since the license expired.</p> <p>FEES ARE NON-REFUNDABLE AND NON-TRANSFERABLE.</p> <p>PRACTICING ON AN EXPIRED LICENSE COULD RESULT IN DISCIPLINARY ACTIONS AND ADDITIONAL MONETARY PENALTIES</p>	<p align="center">Fees-PAYABLE TO COMMONWEALTH OF PA</p> <p>Not practicing in PA after the license expired</p> <p>Submit renewal fee of \$20.00</p> <p>FEES ARE NON-REFUNDABLE AND NON-TRANSFERABLE.</p>
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P. O. Box 2649
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VERIFICATION OF PRACTICE / NON-PRACTICE

*** Your reactivation cannot be processed unless this page is completed ***

Name: _____

Address: _____

City: _____ State: _____

Zip: _____ Phone: _____

Email: _____

License Number: _____

Name of Profession = Optometrist Branch Office

1. Have you engaged in the practice of your profession at this location since the Branch office license lapsed or since you placed it on inactive status?

CIRCLE ONE: YES NO

I understand that any false statement made is subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license and/or certification.

(Signature of Licensee)

(Date)