Commonwealth of Pennsylvania
State Board of Optometry
PO Box 2649
Harrisburg, PA 17105-2649
717-783-7155
www.dos.pa.gov/opt
st-optometry@pa.gov

APPLICATION FOR REGISTRATION OF ADDITIONAL BRANCH PRACTICE LOCATION

1. Attach a check or money order made payable to the "Commonwealth of Pennsylvania" in the amount of $20.00. *NOTE: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. All fees are non-refundable*.

2. This license, when issued, is valid only for the address set forth in this application and is not transferable. A licensee desiring to change the address of his additional office location must submit a new application.

3. A licensee must inform the Board in writing (when no longer practicing at a branch office) to change that location to "inactive status."

OPTOMETRIST'S
FULL NAME: _____
Last Name First Name Middle Name

PENNSYLVANIA LICENSE NO. OE_____

RESIDENCE ADDRESS: _____
Street Address

_____
City State Zip Code

Daytime Phone (_____) _____ Email: _____

PROPOSED BRANCH LOCATION ADDRESS

_____
Street Address

_____ **PA** _____
City State Zip Code

Note: The branch office must be equipped at all times according to § 23.42 of the current Rules and Regulations of the State Board of Optometry.

VERIFICATION STATEMENT

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements made are subject to the penalties of 18 PA C.S. § 4904 relating to unsworn falsification of authorities and may result in the suspension or revocation of my license. 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.

Signature of Optometrist: _____

Date: _____