Virginia Department of Health Professions
Board of Optometry

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EMPLOYMENT VERIFICATION

APPLICANT INFORMATION – **To be completed by applicant.** Please type or print.			
Last Name:	First Name:	Middle Initial:	Other Names Used:
I hereby authorize the release of employment verification to the Virginia Board of Optometry.			
Signature:		Date:	
EMPLOYER OR AUTHORIZED REPRESENTATIVE – **To be completed by employer or authorized representative and mailed directly to the Board.** The individual named above is applying for licensure as an Optometrist in the Commonwealth of Virginia. Please verify the employment history and status of this individual. In lieu of completion of this form, an employer may send an email or letter confirming requested information. If providing via fax, please provide cover sheet as well. **Board staff will not accept faxes without a cover sheet.**			
Employer's Business or Organization Name:			
Type of Business:			
Business Address:			
Phone:	Email Address:		
Employee's Name:		Employee's Position Title:	
Employment Begin Date: (mm/dd/yyyy)		Employment End Date: (mm/dd/yyyy)	
Provide all practice locations and dates of employment. If more space is required, list on separate paper.			
Practice Locations		Dates of Employment	
Print Name:		Signature and Date:	