



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

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:	<input type="checkbox"/> New Sponsor \$ 0.00
	<input type="checkbox"/> Change Sponsor <i>(Apprentice Termination form also required.)</i> \$50.00
	<input type="checkbox"/> Alternate Sponsor <i>(If the apprentice already has a sponsor.)</i> \$ 0.00
Primary Sponsor Name: _____	
License Number: _____ License Type: _____	

PART II Sponsor Information			
Apprentice Name:			
Sponsor Type:	<input type="checkbox"/> Primary	<input type="checkbox"/> Alternate	Training Type: <input type="checkbox"/> Spectacles <input type="checkbox"/> Contacts <input type="checkbox"/> Both
Sponsor Name:			
Full Address:	P.O. Box or Street	City	State Zip
Email Address:		Contact Phone:	
Alaska License Number:		Expiration Date:	
License Type:	<input type="checkbox"/> Optometrist <input type="checkbox"/> Physician <input type="checkbox"/> Dispensing Optician with an endorsement to dispense: <input type="checkbox"/> Spectacles <input type="checkbox"/> Contacts		

PART III Employer Information			
Employer Name:			
Facility Name:			
Facility Address:	Street	City	State Zip

PART IV Notarized Signature

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

I certify under penalty of perjury 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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PO Box 110806, Juneau, AK 99811
Phone: (907) 465-2550

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
<input type="checkbox"/>	Application Fee:		
<input type="checkbox"/>	License or Renewal Fee:		
<input type="checkbox"/>	Other (fine, exam, etc.):		
1.			
2.			
			TOTAL:

Name (as shown on credit card):			
Mailing Address:			
Phone Number:		Email (Optional):	
Signature of Credit Card Holder:			

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

1. Credit Card Number:		All 3 fields MUST be completed. This section will be destroyed after the payment is processed.
2. Expiration Date:		
3. Security Code:		