

**Office of Professional Licensing and Certification  
Application for Renewal - Ophthalmic Dispenser**

**INSTRUCTIONS:** In order to maintain your registration, please complete this application in full and submit with copies of your continuing education certificates/documentation to: **Office of Professional Licensing and Certification, 121 South Fruit Street, Concord, NH 03301.** The application must be accompanied by a check or money order, for \$110.00 for the renewal fee, made payable to: Treasurer, State of New Hampshire. Applications are due at least 30 days prior to the expiration of your registration. All questions can be directed to Connie Beliveau at the address above or at 603-271-9254.

**PERSONAL/BUSINESS INFORMATION**

The information provided in this section is based on your previous registration application. Review the information provided in this section. If any of the information is incorrect or has changed, please make the necessary changes.

Last Name		First Name		Middle Initial		Home Phone		Registration #		Expiration Date	
Home Address				City		State		Zip Code			
Business Address						City		State		Zip Code	
						State		Zip Code		Business Phone	

**CONTINUING EDUCATION**

List below your continuing education courses, events and activities. You are required to complete 8 hours of continuing education per registration period. At least five of those hours must be completed through live, didactic courses. Please attach a copy of each certificate for continuing education hours earned. All original certificates are subject to an audit by the Department of Health and Human Services at any time.

Course/Event/Activity	Location	Name, Address & Phone of Presenter/Sponsor	Begin Date	End Date	Hours	
					Live	Home Study

Are you or have you been registered or licensed in any other state?  Yes  No.  
If yes, which state(s) (indicate dates) \_\_\_\_\_

Have you ever had an application for registration or license denied, had your registration or license suspended or revoked, or had any other disciplinary action taken against you in this or any other state?  Yes  No. If yes, please explain on a separate page.

I certify that the above information is true and accurate, and I understand that original certificates of continuing education are to be made available for inspection by the Department of Health and Human Services upon request.

\_\_\_\_\_  
(Signature) \_\_\_\_\_ (Date Signed)

<b>FOR DEPARTMENT USE ONLY</b>	
<input type="checkbox"/> \$110 Fee/Check # _____	Date Received _____
Effective Dates: _____	Registration Number: _____