The Opticians of Manitoba

"Our Focus Is Your Eyesight"

DISPENSING EXPERIENCE AND FITTINGS FORM

For: - Internationally Educated Professionals
- Graduates of non-accredited Canadian Programs

Please submit one form for each place of employment.

1. FULL LEGAL NAME

First Name: _____

Middle Name(s): _____

Surname: _____

---

2. PERSONAL CONTACT INFORMATION

Home Address: _____

City/Town:_____Province/State:_____ Country: _____

Postal Code:_____ Telephone: _____ Email: _____

---

3. RECORD OF ACTUAL DISPENSING EXPERIENCE

(Laboratory hours are NOT eligible)

Are you self-employed? ❑ Yes ❑ No

Business Name: _____

Business Address: _____

City/Town:_____Province/State:_____ Country: _____

Postal Code:_____ Telephone: _____ Email: _____

First Day Of Employment: _____/_____/_____ (Month/Day/Year)

Last Day Of Employment (Enter N/A if still employed) _____/_____/_____ (Month/Day/Year)

Hours per week of actual dispensing _____

Total actual dispensing hours at the above location _____

---

4. RECORD OF EYEGLASSES AND CONTACT LENS FITTINGS

Number of eyeglass fittings

Multi-focal _____ High myopic [1]_____

High Hyperopic [2]_____ Regular Single Vision [3] _____

Number of contact lens fittings

Soft_____ Rigid Gas Permeable _____

---

5. DECLARATION OF SUPERVISOR *(Please print)*

I, _____, state that the above information is true to the best of my knowledge and belief and that_____ received the above actual dispensing hours during the specified period and/or number of eyeglasses and contact lens fittings under my supervision.

Date: _____ Signature of Supervisor:_____

---

[1] ≥ -6.00

[2] ≥ +4.00

[3] +3.87 to -5.87