KANSAS OPTOMETRY SERVICE PROGRAM

VERIFICATION OF OPTOMETRY PRACTICE

Establishment of an optometric practice in Kansas is required to comply with the agreement you entered into with the Kansas Board of Regents under the Kansas Optometry Service Program. We will continue to verify that you are practicing in Kansas on an annual basis until your contract agreement has been satisfied. (Please print or type)

Name: ____
Last First Middle Maiden

Home Address: ____
Street Address City / State / Zip

Email address: ____

Business Name of Practice: ____

Address of Practice: ____
Street Address City / State / Zip

Telephone Numbers: Home - (_______) __________________ Work - (_______)__________________

Starting Date of Practice: ____
Month Day Year

Relationship (mark all that apply): _____ Owner _____ Employee

_____ Full-time _____ 3/4-time _____ Half-time

____
Signature of Clinic or Office Administrator
(NOT SCHOLARSHIP RECIPIENT)

____ _(_______)________________________
Printed Name and Title Telephone Number

If your plans do not include returning to Kansas to practice, you will be required to repay your loan. Indicate below what your plans are pertaining to establishing a practice.

Thank you for furnishing this information. Please return this form to: Kansas Board of Regents, Kansas Optometry Service Program , 1000 SW Jackson St Suite 520, Topeka, KS 66612-1368; email loldhamburns@ksbor.org or fax 785.430.4233

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