

**Arkansas Board of Dispensing Opticians
Apprentice Quarterly Supervision Report**

To be submitted end of month in February, May, August, November
Report must be received or post-marked no later than 10th day of March, June,
September, December for the previous reporting quarter
Post Office Box 627, Helena, AR 72342 Voice and Fax Line: (870) 572-2847

WEEK Number	7 Day Week Beginning Sunday	7 Day Week Ending Saturday	Total No. Hours Supervised	Apprentice Signature	Supervision Signature
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Total Hours Supervised _____

I, _____, Applicant for Licensure as a Dispensing Optician do affirm that I have been trained under the direct supervision of any Arkansas-licensed optometrist or Arkansas-licensed physician skilled in disease of the eye, the supervisory hours reported above are true and correct to the best of my knowledge.

Signature

Print Name DATE

I, _____, Arkansas Licensed Optometrist or Arkansas Licensed Physician skilled in the disease of the eye holding License Number _____ do affirm that I have supervised the above named apprentice for the hours specified in the report and that the report is true and correct to the best of my knowledge.

Signature

Print Name DATE

I, _____, Arkansas Licensed Optometrist or Arkansas Licensed Physician skilled in the disease of the eye holding License Number _____ do affirm that I have supervised the above named apprentice for the hours specified in the report and that the report is true and correct to the best of my knowledge.

Signature

Print Name DATE