OPTOMETRY
ANCILLARY LOCATION REGISTRATION

Name Of Optometrist:_____ IL License # 046._____

Address Of Record: _____ EMAIL Address:_____
Street

_____ ,IL _____ Telephone: _____
City Zip Code

ANCILLARY LOCATION(S)

1st Location: Name of Facility_____
(If Applicable)

_____ ,IL _____
Street City Zip Code

Telephone _____ Date _____

2nd Location: Name of Facility_____
(If Applicable)

_____ ,IL _____
Street City Zip Code

Telephone _____ Date _____

3rd Location: Name of Facility_____
(If Applicable)

_____ ,IL _____
Street City Zip Code

Telephone _____ Date _____

4th Location: Name of Facility_____
(If Applicable)

_____ ,IL _____
Street City Zip Code

Telephone _____ Date _____

Mail completed registration to:

Department of Financial and Professional Regulation
Division of Professional Regulation
320 W. Washington, 3rd Floor
Springfield, Illinois 62786
Fax: (217) 782-7645