# 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