



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BOARD OF DISPENSING OPTICIANS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

APPRENTICESHIP SUPERVISOR CHANGE

Apprentice Name _____

Address _____

(City) (State) (Phone Number)

Original Supervisor Name _____

License Number _____

Licensed to Practice As _____ Ophthalmologist _____ Optometrist _____ Dispensing Optician

Current Practice Address _____

(Name of Dispensary)

(Address)

(City) (State) (Phone Number)

Date Supervision Ended _____ Send to Board, at the address above, the evaluation form to the ending date indicated by the above Supervisor.

New Supervisor Name _____

Licensed to Practice As _____ Ophthalmologist _____ Optometrist _____ Dispensing Optician

New Practice Address _____

(Name of Dispensary)

(Address)

(City) (State) (Phone Number)

Date Supervision Began: _____ New Supervisor will begin evaluations on this date. Submit the evaluation form at the completion of your six months which may include the dates from the former supervisor. (Example: Your 6 months is 1/1/YR to 7/1/YR but you change supervisors effective 3/13/YR. Have your previous supervisor complete the form until 3/13/YR. The new supervisor would start the evaluation period (1st day with new supervisor) through – 7/1/YR and then every 6 months thereafter.)

Signature New Supervisor

Signature Apprentice

Date