Bureau of Professional Licensing
PO Box 30670 ● Lansing, MI 48909
Telephone: (517) 335-0918
www.michigan.gov/bpl
BPLHelp@michigan.gov

VERIFICATION OF DIAGNOSTIC PHARMACEUTICAL AGENTS (DPA) TRAINING

Authority: 1978 PA 368

Section of Form to be Completed by Applicant:

Applicant's Name (First, Middle, Last)			Date of Birth (MM/DD/YYYY)
Street Address			
City		State	Zip Code
10-Digit MI Permanent ID/License Number	License Expiration Date	Email Address	
List any other name or alias by which you have ever been known, including maiden name, if applicable:			
Signature of Applicant		Date	

Remainder of Form to be Completed by School of Optometry:

Name of School			Telephone Number
Street Address			
City		State	Zip Code
Dates of Training From: _____ To: _____			

CERTIFICATION AND SIGNATURE

I hereby certify that the applicant named above has completed a minimum of 60 classroom hours in general and clinical pharmacology as it relates to the practice of optometry with particular emphasis on the use of diagnostic pharmaceutical agents for examination purposes. Not less than 30 of the 60 classroom hours were allocated to ocular pharmacology and emphasized the systemic effects of, and reactions to, topical ocular diagnostic pharmaceutical agents, including the emergency management and referral of any adverse reactions that may occur.

The doctor named above has also successfully completed an examination on general and ocular pharmacology as it relates to the practice of optometry, with particular emphasis on the use of topical ocular diagnostic pharmaceutical agents, including emergency management and referral of any adverse reactions that may occur.

_____ _____
Signature of Dean or Registrar Title

_____ _____
Print or Type Name Date

(SCHOOL SEAL)

If academic institution has no seal, please indicate