



Bureau of Professional Licensing  
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## 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)