

KENTUCKY BOARD OF OPHTHALMIC DISPENSERS

P. O. Box 1360

Frankfort, KY 40602

Phone: (502) 782-8810 Fax: (502) 564-4818

<http://bod.ky.gov>

**APPLICATION FOR CONTINUING EDUCATION CREDIT
(Must be submitted thirty (30) days prior to program presentation)**

Spectacle _____ Contact Lens _____ Both _____

1. Name of Sponsoring Organization: _____
2. Name of Program Chairman: _____ Work Phone: () _____
3. Address of Program Chairman: _____
4. Date of Program: _____ Street _____ City _____ State _____ Zip _____ Time: _____
5. Program Location (hotel, school, etc.): _____
6. Program Location Address: _____
7. Course Topic: _____ Street _____ City _____ State _____ Zip _____
8. Course Title: _____
9. Method of Presentation (panel, lecture, other/elaborate): _____
10. Is there a co-sponsor to the program? Yes _____ No _____. If yes, please list name and address:

11. Fee to members/employees: \$ _____ Fee to non-members/non-employees: \$ _____
12. Is the course open to non-members? Yes _____ No _____. If yes, how are non-members notified?

13. Number of hours requesting for continuing education credit: _____
14. You must attach a complete proposed outline for the program you are requesting continuing education credit for.
15. You must attach the credentials for the speaker and course objectives.
16. Is this course sponsored by a specific product? Yes _____ No _____. If yes, please explain.

Please note: Courses sponsored or produced by vendors for specific products will not be approved

FOR BOARD USE ONLY

DATE REVIEWED: _____ NUMBER OF HOURS APPROVED: _____ DENIED: _____
REASON FOR DISAPPROVAL: _____
BOARD MEMBER INITIALS: _____