FILED: FEBRUARY 11, 2026

KENTUCKY BOARD OF OPHTHALMIC DISPENSERS

PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING
P.O. Box 1360, Frankfort, Kentucky 40602
500 Mero Street Frankfort, Kentucky 40601 (Overnight Delivery Only)
Phone: (502) 782.8810 | Fax: (502) 564.4818 | Website: bod.ky.gov | Email: BOD@KY.GOV

APPRENTICE CHANGE OF SPONSOR FORM

Pursuant to KRS 326.035(5), an apprentice training schedule and overview of the facilities located at the establishment shall be filed with the Kentucky Board of Ophthalmic Dispensers. This training schedule program shall be designed to encourage apprenticeship training and the development of highly skilled and well-qualified ophthalmic dispensers. KRS 326.035(7) limits the number of apprentices to no more than two (2) apprentices to each active registered Ophthalmic Dispenser in each establishment.

APPRENTICE INFORMATION

Last Name:	First Name:	Middle Initial:	Previous Name:
Mailing Address: Street	City:	State:	Zip Code:
Business Name:	Business Address:		
Telephone Number: ( )	Email Address:	License Number:	
Name of licensed Ophthalmic Dispenser under whom you will receive your training:		License #:	
Is your sponsor the Owner ☐ Manager ☐ Employee ☐ of the company where you will be working?			
Will your work be ophthalmic dispensing under the direct supervision of a licensed Ophthalmic Dispenser? ☐ Yes ☐ No **If no, attach explanation.**			
Name of Previous Sponsor:			
Last Date of Current Sponsorship:	Effective Date of New Sponsorship:		
Apprentice Signature (Required) :	Date:		

SPONSORSHIP AFFIDAVIT

I, the sponsor of record for the above-named apprentice, do hereby certify under penalty of law, that the information contained herein is true, correct, and complete to the best of my knowledge and belief. Further, I accept full responsibility for training the above-named apprentice according to the training schedule (attached) and to encourage the completion of the ABO and NCLE within the two-year apprenticeship term. If, for any reason, the conditions of this supervisory relationship is terminated or changed, I will immediately notify the Board. Further, I do hereby certify that my Kentucky license is current and will be maintained throughout this period.

Sponsor Last Name:	First Name:	Middle Initial:	Previous Name:
Mailing Address: Street	City:	State:	Zip Code:
Business Name:	Business Address:		
Telephone Number: ( )	Email Address:	License Number:	
Are you currently sponsoring another apprentice? Yes ☐ No ☐ **If yes, please list name and license #:**			

***AN OUTLINE OF THE TRAINING SCHEDULE AND AN OVERVIEW OF FACILITES LOCATED AT THE ESTABLISHMENT MUST BE PREPARED BY THE SPONSOR AND FILED WITH THE BOARD WITH THIS FORM.**

Ophthalmic Dispense Sponsor Signature (Required) :	Date:

Form: DPL-BOD-07
REV. December 2025
KRS 326.035
201 KAR 13:050