

NATIONAL OPTICIAN'S PRACTICAL EXAMINATION MASSACHUSETTS - REGISTRATION FORM

EXAMINATION TITLE

National Optician's Practical Examination for Spectacles & Contact Lenses

Please use your full name as it appears on your government-issued identification

Salutation First Name MI Last Name Suffix

Birthdate (REQUIRED) Last 4 Digits of SSN Former Last Name

Preferred Mailing Address City/State/Zip

Home Telephone (include area code) Email Address (REQUIRED)

Name and Address of Opticianry School (if applicable)

Americans with Disabilities Act

Do you have a condition that requires special accommodations for testing? (Per ADA regulations, your condition must be diagnosed by a licensed professional.) You are required to submit need for special accommodation with this registration form.

Examination Fee: \$325

PAYMENT INFORMATION

Select one: Check or Credit Card    

Card Number Expiration Date Cardholder's Zip Code Security Code

Cardholder's PRINTED Name Cardholder's Signature

Cardholder's Address City/State/Zip

EMPLOYMENT HISTORY IN OPTICIANRY

MOST RECENT EMPLOYER

Company City/State/Phone Job Title Dates of Employment

I hereby attest the above information is true and accurate.

Signature Date

You MUST sign the registration form. Please use your full name as it appears on your government-issued ID.

Return registration form to:

NCSORB, 2025 Woodlane Drive, St. Paul, MN 55125-2998 or fax to: (651) 731-0410

NATIONAL OPTICIAN'S PRACTICAL EXAMINATION MASSACHUSETTS - RETEST FORM

EXAMINATION TITLE

NATIONAL OPTICIAN'S PRACTICAL EXAMINATION FOR SPECTACLES & CONTACT LENSES

Please use your full name as it appears on your government-issued identification

Salutation First Name MI Last Name Suffix

Birthdate (REQUIRED) Last 4 Digits of SSN

Preferred Mailing Address City/State/Zip

Telephone (REQUIRED) Email Address (REQUIRED)

Americans with Disabilities Act

Do you have a condition that requires special accommodations for testing? (Per ADA regulations, your condition must be diagnosed by a licensed professional.) You are required to submit need for special accommodation with this registration form.

Examination Fee: \$275

Last Exam Date: _____

ASSIGNED RETEST EXAMINATIONS

- Pupillary Distance Segment Height Neutralization Corneal Curvature Images Slit Lamp Operations
 Evaluation of a Contact Lens Spectacles Multiple Choice Contact Lens Multiple Choice

PAYMENT INFORMATION

Select one: Check or Credit Card    

Card Number Expiration Date Security Code

Cardholder's PRINTED Name Cardholder's Signature

I hereby attest the above information is true and accurate.

Signature Date

You **MUST** sign the registration form. Please use your full name as it appears on your government-issued ID.

Return retest form to:

NCSORB, 2025 Woodlane Drive, St. Paul, MN 55125-2998 or fax to: (651) 731-0410