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 ❑ VISA ❑ ❑ ❑

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

❑ Spectacles Multiple Choice ❑ Contact Lens Multiple Choice

PAYMENT INFORMATION

Select one: ❑Check or ❑Credit Card ❑ VISA ❑ MasterCard ❑ American Express ❑ DISCOVER

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