



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Board of Examiners in Optometry

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APPLICATION FOR INACTIVE LICENSURE STATUS

Name of Licensee: _____ License Number: _____

Address: _____

City _____ State _____ Zip code _____

Telephone Number: (W) _____ (H) _____

Email Address: _____

The undersigned, being duly sworn deposes and says that he or she is the person who executed this application; that the statements contained herein are true and correct to the best of his or her knowledge and belief; that he or she has suppressed any information that might affect this application; that he or she will abide by the ethical standards and conduct of this profession; and has read and understands this affidavit.

I am aware that while I am on inactive status licensure, I may not practice optometry in the State of Maryland.

Signature of licensee

Date

Subscribed and sworn to before me this _____ day of _____ 20_____

Notary Public

My commission expires _____

A Fee of \$250 must accompany this application