

**APPLICATION FOR APPROVAL OF CLINICAL OBSERVATION
FOR CONTINUING EDUCATION**

Name of Facility: _____

Address of Facility:

Name of participating optometrist and/or ophthalmologist:

(Please enclose CV's of each)

Please provide a brief history of the above facility's educational activities. (e.g. sponsorship of seminars, training of residents, supervision of externs) Attach an extra sheet if needed.

Provide a brief description of the activity observed by the optometrist.

Approved: _____

Number of TPA Hours _____

(Maximum of 6 hours allowed every renewal)

Date: _____

Reviewer's signature _____