



Provider Application

Thank you for your interest in the 1-800 CONTACTS Provider Network. As part of this program, 1-800 CONTACTS will be referring its customers to eye care providers across the country for contact lens exams. With the customer's consent and in accordance with the terms of the Fairness to Contact Lens Consumers Act, 1-800 CONTACTS will be acting as our customer's designee to request and receive a copy of their contact lens prescription from you. In order to ensure that all eye care providers participating in the program are properly licensed and qualified, 1-800 CONTACTS is requesting the following information from you regarding your professional credentials and current optometric practice. Please fill in the information, attach the necessary documents and fax the completed form to 1-800-501-5067.

Name of Business _____

Business Address (s) _____

City _____ State _____ Zip _____

Phone # _____ Fax # _____

Email Address _____

Business Hours _____

Years in business _____ # Employees _____

U&C Fees: Eyeglass Exam \$ _____

U&C Fees: Contact Lens Exams: Spherical \$ _____ Specialty \$ _____ I&R \$ _____

Doctor's Name, Degrees and Name of Professional School(s):

State Licenses Held _____

Has any state board revoked or suspended your license to practice? If yes, please explain: _____

If credentialed, by which organization? _____ When? _____

What levels of professional liability insurance do you carry? _____

Are you currently an employee, consultant, clinical investigator or stockholder of any contact lens manufacturer? If yes, explain: _____

Please attach a photocopy of your current state license, along with a copy of your professional liability insurance coverage.

By signing below, you acknowledge that (i) the information supplied in this application is correct and accurate and (ii) you agree to abide by the contact lens prescription release provisions, as well as all other provisions, of the Fairness to Contact Lens Consumers Act.

Signature _____ Date _____