****

**CERTIFICATION**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

To whom it may concern:

This is to certify that **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** underwent routine eye exam on **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** due to (symptoms) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

**Examination done: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Recommendation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **SPECTACLE Rx** | | | | | | | |
|  | **UVA** | **SPHERE** | **CYLINDER** | **AXIS** | **ADD** | **PD** | **BCVA** |
| **OD** |  |  |  |  |  |  |  |
| **OS** |  |  |  |  |  |  |  |

This certification is issued upon the request to the patient for whatever legal purpose this may serve.

Respectfully yours,

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE OVER PRINTED NAME**

*Optometrist*

License No.:  **\_\_\_\_\_\_\_\_\_**  
PTR No.: **\_\_\_\_\_\_\_\_\_\_\_\_\_**