

Form 4101 Rev. 6/2025

Submit Electronically
through SOSPortal

Do not Mail

Filing Fee: \$150



**VISION SUPPORT ORGANIZATION
REGISTRATION**

This space reserved for office
use only.

- ☐ Initial Registration
☐ Renewal of Registration

Registration Number: _____

(Applicable for renewals only)

Vision Support Organization Information

Vision Support Organization (VSO) Name: _____

Business Address (Please include street address, city, state and zip code): _____

Mailing Address (if different from above): _____

Contact Name: _____

Contact Email Address: _____ Contact Phone: _____

Ownership Information

List each optometrist who owns any portion of the VSO as well as each person who is not an optometrist and owns 5% or more of the VSO. For each person named, select either optometrist owner or non-optometrist owner. See instructions for additional information. Include Vision Support Organization ownership information addendum as necessary if number of owners exceeds space provided.

Name: _____	Optometrist Owner: <input type="checkbox"/>	Non-Optometrist Owner: <input type="checkbox"/>
Business Address (Please include street address or P.O. box, city, state and zip code): _____		

Name: _____	Optometrist Owner: <input type="checkbox"/>	Non-Optometrist Owner: <input type="checkbox"/>
Business Address (Please include street address or P.O. box, city, state and zip code): _____		

Name: _____	Optometrist Owner: <input type="checkbox"/>	Non-Optometrist Owner: <input type="checkbox"/>
Business Address (Please include street address or P.O. box, city, state and zip code): _____		

Name: _____	Optometrist Owner: <input type="checkbox"/>	Non-Optometrist Owner: <input type="checkbox"/>
Business Address (Please include street address or P.O. box, city, state and zip code): _____		

Business Support Services Provided to Optometrists

Identify each licensed optometrist and entity that employs or contracts with an optometrist to provide eye care services in Texas with which the VSO has entered into a vision support agreement to provide two or more business support services. Identify the type of business support services provided. Include Vision Support Organization business support services addendum as necessary if number of optometrists exceeds space provided.

Optometrist Name: _____
Name of Professional Entity or Optometry Practice: _____
Business Address (Please include street address, city, state and zip code): _____
Describe all business support services provided: _____

Optometrist Name: _____
Name of Professional Entity or Optometry Practice: _____
Business Address (Please include street address, city, state and zip code): _____
Describe all business support services provided: _____

Optometrist Name: _____
Name of Professional Entity or Optometry Practice: _____
Business Address (Please include street address, city, state and zip code): _____
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Optometrist Name: _____
Name of Professional Entity or Optometry Practice: _____
Business Address (Please include street address, city, state and zip code): _____
Describe all business support services provided: _____

Attachments

The following items are included with this registration:

1. \$150 filing fee;
2. Vision Support Organization ownership information addendum and Vision Support Organization business support services addendum, as necessary.

Execution

Date: _____

By: _____

Name of vision support organization (see instructions)

Signature of authorized person (see instructions)

Printed or typed name of authorized person