This space reserved for office Form 4101 Rev. 6/2025 use only. Submit Electronically through SOSPortal Do not Mail VISION SUPPORT ORGANIZAT ON REGISTRATION Filing Fee: \$150 Initial Registration Renewal of Registration gis lation Number: (Ap licable for rev wals Vision Support Organization Information Vision Support Organization (VSO) Name: ty, tate and zip cod Business Address (Please include street addre Mailing Address (if different from al Contact Name: Contact Email Address: Contact Phone: Ownership Information List each optom. It who owns any portion of he VSC 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 instruction for additional informatio. Include Vision Support Organization ownership information addendum as necessar, frumber of owners exceeds spine provided. Non-Optometrist Optometrist Owner: Owner: Business Address (Pleas nclua street address or P.O. box, city, state and zip code): Non-Optometrist Owner: Name: Optometrist Owner: Business Actress (Yease include street address or P.O. box, city, state and zip code): Non-Optometrist Optometrist Owner: Owner: Name: Business Address (Please include street address or P.O. box, city, state and zip code): Non-Optometrist Name: Optometrist Owner: Owner:

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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 optometry to provide a configuration of the services in Texas with which the VSO has entered into a vision support agreement to provide a configuration of make business support services. Identify the type of business support services provided. Include Viras Support or anization 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 I acuce	
Business Address (Please include street ada. 188, city, state and ap code).	
Describe all business support ervices provided:	
Optometrist N me	
Name of Professional Entity or Optometry Proctice.	
Business \ddress (Please include s veet a 'dress, city, state and zip code):	
De cribe Ill business support services provided:	
Optometrist Nan. :	
Name CPre ession al Entity or Optometry Practice:	
Bus Less Ad ress (Please include street address, city, state and zip code):	
Describe all business support services provided:	

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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.

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Date:	By:	
	<u> </u>	Name of vision support organicus (see instructions)
		Signature of authoriz 1 persor (see instructions)
		Printed or type 'name or authorized person

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