Optician Application for Examination

Board of Opticianry
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: https://floridasopticianry.gov/
Email: info@floridasopticianry.gov
Phone: (850) 245-4474
FAX: 850-921-5389

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P.O. Box 6330
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Do Not Write in this Space
For Revenue Receipting Only

Important: ALL applicants must be at least 18 years of age.

Licensure Examination (2001) **$100.00**

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Application fees are non-refundable.

1. PERSONAL INFORMATION

Name: ____ **Date of Birth:** __________
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

______________________________ ________ ____________________
Street/P.O. Box Apt. No. City

______________________ ________ ____________ ____________________
State Zip Country Home/Cell Telephone (Input without dashes)

Practice Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website)

______________________________ ________ ____________________
Street Apt. No. City

______________________ ________ ____________ ____________________
State Zip Country Work/Cell Telephone (Input without dashes)

EQUAL OPPORTUNITY DATA:
We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43 CFR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: ☐ Male ☐ Female

Race: ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ Two or More Races ☐ Hispanic or Latino ☐ Black or African American ☐ White ☐ Asian

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

☐ Yes ☐ No Email Address: ______________________________

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE (REQUIRED)

This information is exempt from public records disclosure.

Pursuant to 42 U.S.C. § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, Section 456.013(1)(a), F.S., authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: ____

First Name: ____

Middle Name: ____

Social Security Number: _____________________________________
(Input without dashes)

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. **In this instance, Social Security numbers are mandatory** pursuant to Title 42 United States Code, Section 653 and 654; and Sections 456.013(1), 409.2577, and 409.2598, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: ______________________________

3. ELIGIBILITY DATA

Indicate the method by which you qualify to sit for the Opticiary Examination. Select only one:	
☐ I. Apprenticeship Program	☐ II. Associate Degree in Opticianry or equivalent
☐ III. Licensed by examination in another state/ territory/jurisdiction	☐ IV. Actively practiced in another state/territory/ jurisdiction where licensure is not required

Provide the requested information/documentation only in the section below that corresponds to the method by which you qualify.

☐ **I. Apprenticeship Program**

A. Did you complete 6,240 hours of training under a registered sponsor within five years after the date of your registration with the Florida Department of Health? ☐ Yes ☐ No

B. Provide your Registered Apprentice Number: **DA** ____________________

If Registered Apprentice Number cannot be provided, submit a copy of your apprenticeship completion letter.

☐ **II. Associate Degree in Opticianry or Equivalent**

A. Have you received an associate degree in opticianry or equivalent from an accredited school?
☐ Yes ☐ No

B. Provide the following about the institution where you received your degree:

School Name	City/State or Country	Dates of Attendance (From-To) MM/DD/YYYY	Degree Awarded

☐ **Transcripts must be sent in the official sealed envelope directly from the university. Send by mail or via electronic secure transfer to MQA.Opticianry@flhealth.gov. Diplomas and student copies are not acceptable.**

☐ **III. Licensed by examination in another state/territory/jurisdiction** (of the United States and actively practiced in that state for at least three of the last five years)

A. List the **active opticianry license** from the state(s) in which you have actively practiced for three of the last five years.

License Type	License #	State/Country	Original Date Issued	Expiration Date	Status of License

☐ **Submit a License Verification** form to **each** state in which you hold an **active license** in opticianry. License verifications must be received directly from the licensing authority. **A copy of your license will not be accepted** in lieu of official verification from the licensing agency.

☐ **IV. Actively practiced in another state/territory/jurisdiction** (of the United States in which licensure is not required, for at least five of the last seven years.)

☐ If you practiced opticianry in a state that does not require a license, **provide tax records or business records, and an affidavit** showing proof of at least five years of opticianry practice within the last seven years.

All eligibility documentation should be submitted directly to the board office at:

Board *of* Opticianry
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3257

Name: ______________________________

4. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

____

B. Do you hold, or have you ever held a license to practice opticianry or any other health-related license(s)?
☐ Yes ☐ No

C. List all health-related licenses (active, inactive or lapsed), unless provided on page 4.

License Type	License #	State/Country	Original Date Issued	Expiration Date	Status of License

☐ **Submit a License Verification** form to **ALL** your state(s) of licensure. License verifications must be received directly from the licensing authority regardless of the status of the license. **A copy of your license will not be accepted** in lieu of official verification from the licensing agency.

D. Starting with the most recent, list all opticianry work experience, employment outside of an optical setting, or any other unaccounted period of time. Do not leave any blanks or lapses in time. Attach additional sheets if necessary.

Name of Business	Full Mailing Address	Employment Dates (From-To) MM/DD/YYYY

Duties Performed: ______________________________

____

Name of Business	Full Mailing Address	Employment Dates (From-To) MM/DD/YYYY

Duties Performed: ______________________________

____

Name of Business	Full Mailing Address	Employment Dates (From-To) MM/DD/YYYY

Duties Performed: ______________________________

____

Name: ______________________________

5. **DISASTER**

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? ☐ Yes ☐ No

6. **EDUCATION HISTORY**

A. Have you earned a high school diploma or equivalent? ☐ Yes ☐ No

B. Provide the following information about your high school or equivalent:

School Name	School Address	Graduation Date	Degree Awarded
			☐ Diploma ☐ GED

☐ **Include a photocopy of your high school diploma or equivalency certificate.**

7. **EXAMINATION/CERTIFICATION HISTORY**

A. **American Board of Opticianry (ABO) Requirements:** All applicants must have received a passing score on the National Opticianry Competency Examination no more than three years prior to the date of application **or** have current ABO certification and must provide one of the following:

☐ Proof of passing the National Opticianry Competency Examination

OR

☐ Photocopy of current ABO certification

B. **National Contact Lens Examiners (NCLE) Requirements:** All applicants must have received a passing score on the Contact Lens Registry Examination no more than three years prior to the date of application **or** have current NCLE certification and must provide one of the following:

☐ Proof of passing the Contact Lens Registry Examination

OR

☐ Photocopy of current NCLE certification

For more information regarding the ABO and NCLE, you may visit their website at www.abo-ncle.org **or contact them directly at 1-800-296-1379**.

The Board of Opticianry does not offer an examination review course, nor does it endorse any.

Supporting documentation not submitted with the application may be submitted electronically to MQA.Opticianry@flhealth.gov or mailed directly to the board office at:

Board *of* Opticianry
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3257

Name: ______________________________

This information is exempt from public records disclosure.

8. HEALTH HISTORY

If you fail to disclose the information requested in this section, your application may be denied.

1. Do you have any condition that currently impairs your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No

2. Are you using medications, other drugs, narcotics, or intoxicating chemicals that impair your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you are required to send the following items directly to the board office:

☐ **A letter from a Licensed Health Care Practitioner**, who is qualified by skill and training to address your condition, which explains the impact your condition may have on your ability to practice your profession with reasonable skill and safety and states either that you are safe to practice your profession without restriction or indicating what restrictions are necessary. Documentation must be current within the last year.

☐ **A written self-explanation**, explaining the medical condition(s) or occurrence(s) and current status.

Name: ______________________________

9. DISCIPLINE HISTORY

A. Have you ever been denied licensure, certification, or registration for opticianry or any health-related profession or the renewal thereof in any state? ☐ Yes ☐ No

B. Have you ever been denied the right to take an opticianry licensure examination? ☐ Yes ☐ No

C. Have you ever had a license to practice any profession revoked, suspended, or otherwise acted against in a disciplinary proceeding in any state? ☐ Yes ☐ No

D. Is there currently pending, in any jurisdiction, a complaint or investigation against your professional conduct or competency? ☐ Yes ☐ No

E. Have you ever been involved in, reprimanded for or disciplined by an employer or educational institution for misconduct including fraud, misrepresentation, academic misconduct, theft or sexual harassment?
☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, complete the following:

Name of Agency	State	Action Date: MM/DD/YYYY	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

☐ A copy of the **Administrative Complaint** and **Final Order**.

10. CRIMINAL HISTORY

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld. ☐ Yes ☐ No

Reckless driving, driving while license suspended or revoked (DWSLR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

If you responded "Yes," complete the following:

Offense	Jurisdiction	Date: MM/DD/YYYY	Final Disposition	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding each offense; including dates, city and state, charges and final results.

☐ **Final Dispositions** and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

☐ **Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: ______________________________

11. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in Section 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 2.

   a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under Section 893.13(6)(a), F.S.)? ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation?

   ☐ Yes ☐ No

   d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed (if "Yes," please provide supporting documentation)?

   ☐ Yes ☐ No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? ☐ Yes ☐ No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, F.S.? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 4.

   a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? ☐ Yes ☐ No

Name: ______________________________

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 5.

a. Have you been in good standing with a state Medicaid program for the most recent five years?

☐ Yes ☐ No

b. Did termination occur at least 20 years before the date of this application? ☐ Yes ☐ No

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written explanation** for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the address listed on the first page of the application.

☐ **Supporting documentation** including court dispositions or agency orders where applicable.

Documentation for sections 8, 9, 10, and 11 must be mailed to:

Board *of* Opticianry
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3257

Documentation submitted to the board must be in English. Any documents in a language other than English must be translated by a certified translator, who is not related to the applicant.

12. APPLICANT SIGNATURE

I, the undersigned, affirm that I am the person identified in this application for licensure in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to Sections 456.067, 775.083 and 775.084, F.S.

Florida law requires you to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

The practice of opticianry in Florida is governed by Chapters 456 and 484, Part I, F.S., and Chapter 64B12, F.A.C., which I state I have read and understand. I understand that it is my responsibility to keep informed of any changes to Chapters 456 and 484, Part I, F.S., and Chapter 64B12, F.A.C.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature ______________________________ Date ______________
You may print this application and sign it or sign digitally. MM/DD/YYYY

Complete verifications must be mailed directly from the verifying agency to:

Board *of* Opticianry
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3257

Florida Board *of* Opticianry License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: ____

Address: ____

Name original license was issued under: ______________________________

License Number: ____________________ State: ____________________

I hereby authorize release of any information regarding my licensure status to the Florida Board Opticianry.

Applicant Signature: ______________________________ Date: ______________

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

* Typed on an official state form or letterhead
* Include an official board seal
* Signature and title of state board official

The following information must be included in all verifications:

* Licensee name
* License number
* State or jurisdiction of licensure
* Licensure status
* Is license in good standing?
* Date of issuance/expiration
* Licensure method (examination, grandfathering, reciprocity/endorsement)
* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.