Optician Apprentice Application for Registration

Board of Opticianry
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: www.floridasopticianry.gov
Email: info@floridasopticianry.gov
Phone: (850) 245-4292
Fax: (850) 413-6982

Florida HEALTH
Medical Quality Assurance

Are you an active duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered "Yes" to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health's commitment to serving members and veterans of the United States Armed Forces and their families online at

http://www.flhealthsource.gov/valor

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Do Not Write in this Space
For Revenue Receipting Only

There is no provision in chapter (ch.) 484, Part I, Florida Statutes (F.S.), or Rule ch. 64B12, Florida Administrative Code (F.A.C.), to allow credit for any time worked prior to registration in the apprentice program.

Apprentice Optician (2002) **$60.00**

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. The application fee is 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 (Place of Employment) Suite 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 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 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 Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 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 § 653 and 654; and s. 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. APPLICANT BACKGROUND

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

_____

4. EDUCATION HISTORY

List high school/college/university education, whether completed or not, in chronological order.

School Name	City/State or Country	Graduation Date (MM/DD/YYYY)	Degree Awarded

☐ **Provide a photocopy of your high school diploma, transcript or equivalency certificate.** If you attended a postsecondary school and want credit toward your apprenticeship hours, each credit hour earned at such school shall count as 86.67 apprenticeship hours. See Rule 64B12-16.003(4), F.A.C. A transcript will not be considered official if received from the applicant. Transcript must be sent in the official sealed envelope directly from the university. Send via electronic secure transfer to MQA.Opticianry@flhealth.gov or by mail to:

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

Documents in a foreign language must be translated in English by a certified translator, who is not related to the applicant.

5. SPONSOR INFORMATION

- *Approved sponsors include opticians licensed in Florida for at least one year, Florida licensed optometrists, Florida licensed allopathic physicians, and Florida licensed osteopathic physicians with a clear, active license. An approved sponsor may only sponsor a total of two apprentices at one time and an apprentice may have no more than two sponsors at one time.*
- *A licensed optician that is not board certified may not train an apprentice in filling contact lens prescriptions and fitting and adapting contact lenses. Training in contact lenses must be provided by a Florida board-certified optician, a Florida licensed optometrist, a Florida licensed allopathic physician, or a Florida licensed osteopathic physician. See Rule 64B12-16.003(6)(h), F.A.C.*
- *If your sponsor does not qualify to train you in contact lenses, you must find a sponsor who is qualified to train you or complete a Board approved course equivalent to 32 hours as a substitute for working experience with contact lenses.*

Primary
Sponsor Name: _____ Primary Sponsor License #: _____
☐ Optician ☐ Board Certified Optician ☐ Optometrist ☐ Allopathic Physician ☐ Osteopathic Physician

Secondary
Sponsor Name: _____ Secondary Sponsor License #: _____
☐ Optician ☐ Board Certified Optician ☐ Optometrist ☐ Allopathic Physician ☐ Osteopathic Physician

Name: _____

This information is exempt from public records disclosure.

6. HEALTH HISTORY

Physical and Mental Health Disorders Impacting Ability to Practice

A. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

B. In the last two years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental or physical disorder that impaired your ability to practice? ☐ Yes ☐ No

Substance-Related Disorders Impacting Ability to Practice

C. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or would impair your ability to practice? ☐ Yes ☐ No

D. During the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol or drug) disorder or, if you were previously in such a program, did you suffer a relapse? ☐ Yes ☐ No

E. During the last five years, have you been enrolled in, required to enter, or participated in any substance-related (alcohol or drug) recovery program or impaired practitioner program for treatment of drug or alcohol abuse? ☐ Yes ☐ No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

☐ **A letter from a Licensed Health Care Practitioner,** who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

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

Name: _____

7. 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 had any professional license or license to practice revoked, suspended, or any other disciplinary action taken in any state or other jurisdiction? ☐ Yes ☐ No

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

D. Is there a complaint or investigation against your professional conduct or competency currently pending in any jurisdiction? ☐ 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**.

8. 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.

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. ☐ Yes ☐ No

If you responded "Yes" in this section 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: _____

9. 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 s. 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 ch. 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 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 s. 893.13(6)(a), F.S)? ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under s. 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," 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 s. 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

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

Name: _____

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 (LEIE)? ☐ Yes ☐ No

   a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? ☐ Yes ☐ No

   b. If you responded "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? ☐ Yes ☐ No

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

☐ **A written self-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.

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

Documents in sections 6, 7, 8, and 9 must be mailed to the board office at:

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

10. APPLICANT SIGNATURE

I, the undersigned, state 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 s. 456.067, F.S.

Florida law requires me 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.

I hereby state that my sponsor and I have reviewed, together, ch. 484, Part I, F.S, and ch. 64B12, F.A.C., and specifically Rule ch. 64B12-16, F.A.C. I fully understand my responsibilities to my sponsor, the Board of Opticianry and the Department of Health, and the limitations of being registered in the apprenticeship program herein designated. I understand that it is my responsibility to keep informed of any changes to ch. 484, Part I, F.S., and 64B12, F.A.C.

I understand that pursuant to Rule 64B12-16.003(4)(a), F.A.C., I am required to complete a two-hour Apprentice/Sponsor Orientation course within one year of registration in the apprenticeship program. I have also informed my sponsor(s) that if they attend a two-hour Apprenticeship/Sponsor Orientation course, the course will count toward either the elective or the laws and rules continuing education requirement for the renewal of their optician license.

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 out the application and sign it or sign digitally. MM/DD/YYYY

This form is required for all applicants.
Complete registration forms must be mailed directly from the sponsor to:

Board *of* Opticianry
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3258

Board of Opticianry Sponsor Registration Form

- *Approved sponsors include opticians licensed in Florida for at least one year, Florida licensed optometrists, Florida licensed allopathic physicians, and Florida licensed osteopathic physicians with a clear, active license. An approved sponsor may only sponsor a total of two apprentices at one time and an apprentice may have no more than two sponsors at one time.*
- *A licensed optician that is not board certified may not train an apprentice in filling contact lens prescriptions and fitting and adapting contact lenses. Training in contact lenses must be provided by a Florida board-certified optician, a Florida licensed optometrist, a Florida licensed allopathic physician, or a Florida licensed osteopathic physician. See Rule 64B12-16.003(6)(h), F.A.C.*
- *If your sponsor does not qualify to train you in contact lenses, you must find a sponsor who is qualified to train you or complete a Board approved course equivalent to 32 hours as a substitute for working experience with contact lenses.*

Apprentice Information

Apprentice Full Name: _____

Number of hours this apprentice will work per week under direct supervision of a sponsor: _____

Primary Sponsor General Information

Sponsor Name _____ Business Name _____

Address/City/State/ZIP _____

Telephone Number _____ Fax _____

Primary Sponsor License # _____ Profession _____

Rule 64B12-16.003, F.A.C., requires the apprentice to complete training in filling, fitting and adapting contact lenses as a part of the apprenticeship training. Will this training be provided by the primary sponsor?

☐ Yes ☐ No **(You must check one.)**

Secondary Sponsor General Information (if applicable)

Secondary Sponsor Name _____ Business Name _____

Address/City/State/ZIP _____

Telephone Number _____ Fax _____

Secondary Sponsor License # _____ Profession _____

Rule 64B12-16.003, F.A.C., requires the apprentice to complete training in filling, fitting and adapting contact lenses as a part of the apprenticeship training. Will this training be provided by the secondary sponsor?

☐ Yes ☐ No **(If this section is completed, you must check one.)**

Board of Opticianry Sponsor Registration Form

Apprentice Full Name: _____

I state that I dispense eyewear and maintain all of the equipment required by Rule 64B12-10.007, F.A.C., on the same premises where the apprentice works. I further state that my apprentice and I have reviewed, **together**, ch. 484, Part I, F.S., and Rule 64B12-16, F.A.C., I declare that I fully understand my responsibilities to my apprentice and to the Board of Opticianry and the Department of Health, as a properly registered sponsor of an apprentice registered in the opticianry apprenticeship program.

_____ _____

Primary Sponsor Signature Date (MM/DD/YYYY)

_____ _____

Secondary Sponsor Signature (if applicable) Date (MM/DD/YYYY)