Initial Optometry Faculty Certificate Application

Board of Optometry
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: www.floridasoptometry.gov
Email: info@floridasoptometry.gov
Phone: (850) 245-4355
FAX: (850) 922-8876

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

Optometry Faculty Certificate (1805) **$205.00**

Total fee of $205.00 includes the following:

Application Fee	$100.00
Licensure Fee	$100.00
Unlicensed Activity Fee	$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a $105.00 (Licensure Fee and Unlicensed Activity Fee) refund. Requests to withdraw or for a refund must be made in writing. Certain fees are refundable for up to three years from the date of receipt.

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)

Physical 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

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. 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 Optometry or any other health-related license(s)?
☐ Yes ☐ No

C. List all health-related licenses (active, inactive or lapsed).

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.

D. Have you committed any act or offense in any jurisdiction which would constitute the basis for discipline?

☐ Yes ☐ No **If you respond "Yes,"** provide a **written self-explanation** and provide **documentation**.

4. EDUCATION HISTORY

A. Are you a graduate of an accredited school/college of optometry that is approved by an accrediting agency recognized by the United States Office of Education? ☐ Yes ☐ No

B. Have you completed at least 110 hours of transcript quality coursework? If so, select the appropriate category: ☐ Yes ☐ No

Graduate of:

☐ Ferris State College (1979)	☐ Ohio State (1972)	☐ University of California, Berkeley (1977)
☐ Illinois College (1976)	☐ Pacific University (1977)	☐ University of Houston (1975)
☐ Indiana University (1976)	☐ Pennsylvania College (1976)	☐ University of Missouri (1984)
☐ Inter-American (1986)	☐ Southern California (1979)	☐ University of Montreal (1983)
☐ Newenco (1977)	☐ Southern College (1976)	☐ Waterloo, Canada (1976)
☐ Northeastern State (1983)	☐ SUNY (1975)	
☐ Nova Southeastern (1993)	☐ University of Alabama (1973)	

C. Have you completed clinical training in general and ocular pharmacology? ☐ Yes ☐ No

Name: _____

This information is exempt from public records disclosure.

5. 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: _____

6. 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 following questions, please provide:

☐ **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 to the address listed on the first page of the application.

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

7. PRACTICE INFORMATION

List the Florida-based school/college where you have been offered and accepted a full-time faculty appointment to teach in a program of optometry.

_____

(School/College Name)

☐ **You must submit a letter on letterhead from the Dean of the program confirming the appointment.**

8. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to 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.

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

Applicant's Signature _____ Date _____

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

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

Florida Board *of* Optometry
4052 Bald Cypress Way Bin C-07
Tallahassee, FL 32399-3257

Florida Board *of* Optometry 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 of Optometry.

Applicant's 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.