Application for Licensure as a Certified Optometrist

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

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

Florida HEALTH
Medical Quality Assurance

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Do Not Write in this Space For Revenue Receipting Only

☐ **Initial Licensure** (1010) **$555.00**	☐ **Upgrade to Certified Optometrist** (1030) **$275.00**
Total fee of $555.00 includes the following:	**Total fee of $275.00 includes the following:**
Application Fee (non-refundable) $250.00 Initial Licensure Fee (refundable) $300.00 Unlicensed Activity Fee (refundable) $5.00	Application Fee (non-refundable) $250.00 Duplicate License Fee (refundable) $25.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. 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 served in the Armed Forces? ☐ Yes ☐ No

If you responded "Yes," provide the following information:

Enlistment Date: ____________ Separation Date: ____________ Type of Discharge: ____________

a. Have you ever been a defendant in a military court-martial? Do not include parking or speeding violations.
☐ Yes ☐ No

E. Are you under investigation or prosecution for a crime in any jurisdiction? ☐ Yes ☐ No

F. Have you ever been arrested or criminally or civilly charged with any intentional or negligent action related to the use or misuse of drugs, alcohol, or illegal chemical substances? ☐ Yes ☐ No

G. Are you under investigation or pending administrative action by the licensing authority of any jurisdiction, including its agencies and subdivisions? ☐ Yes ☐ No

H. Are you currently, or have you ever been, registered with the United States Drug Enforcement Administration? ☐ Yes ☐ No

If **"Yes,"** provide your DEA Registration Number: ____________

Registration Status: ☐ Current ☐ Formerly Registered

Name: ____________________

4. EDUCATION & TRAINING HISTORY

A. List undergraduate, graduate, and professional Optometric education, listing all schools/colleges/universities attended, in chronological order.

School Name	City/State	Graduation Date	Degree Awarded

☐ **All applicants must have an official transcript forwarded directly to the board office from your educational program. Diplomas and student copies are not acceptable. Transcripts should be sent to:**

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

B. I am applying to take the Certified Optometrist Examination [select only **one**]:

☐ Based on graduation from one of the following board-approved schools or colleges of optometry, which has certified to the board that the graduates received at least 110 hours of approved coursework in general and ocular pharmacology, including training, that has facilities for both didactic and clinical instructions in pharmacology; and that requires students to pass the National Board of Examiners in Optometry (NBEO) Applied Basic Sciences (ABS) (Part 1) Examination.

☐ Chicago College of Optometry	☐ Michigan College of Optometry	☐ Southern California College
☐ Inter-American University (Puerto Rico)	☐ Midwestern University- Arizona	☐ Southern College
☐ Kentucky College of Optometry	☐ Nova Southeastern	☐ University of Alabama

OR

☐ Upon graduation from and completion of 110 hours of transcript quality coursework and clinical training in general and ocular pharmacology from a school or college approved by the board and accredited by a regional or professional accrediting organization that is recognized and approved by the Commission of Recognition of Postsecondary Accreditation or the United States Department of Education, and that has facilities for both didactic and clinical instruction in pharmacology.

School Name	Graduation Date

C. I completed at least one year of supervised experience in differential diagnosis of eye disease or disorders as part of the optometric training or in a clinical setting as part of the optometric experience at:

Location of Supervised Experience	Supervisor's Name

Name: ______________________________

This information is exempt from public records disclosure.

5. EXAMINATION HISTORY

☐ **All applicants must provide National Board of Examiners in Optometry Scores:**

Official NBEO Scores for **Parts I** (ABS), **II** (PAM- which includes the TMOD), **III** (including separate scores for the **Clinical Skills Examination**) and the **Florida Practical Skills Examination** (which includes Biomicroscopy, Binocular Indirect Ophthalmoscopy and Dilated Biomicroscopy and Non-Contact Fundus Lens Evaluation skills), and **IV** (Florida Laws and Rules) must be sent via email directly from the National Board to:

MQA.Optometry@flhealth.gov

Passing scores for all parts of the NBEO Licensure Examination **must have been achieved within three years preceding the application for licensure or within three years following the submission of the application.**

All applicants must provide official documentation of passing **Part I** (Applied Basic Sciences) portion of the examination offered by NBEO.

This documentation is required to demonstrate that the applicant is a graduate from a Florida Board of Optometry approved education program. **Part I** is not considered part of the **Florida Licensure Examination**, therefore, the three-year period for scores does not apply to this section.

A. Have you taken any parts of the Florida Licensure Examination, including the Florida Practical Examination with the three years preceding this application? ☐ Yes ☐ No

B. Have you achieved a passing score on the NBEO Part I, Applied Basic Science (ABS) examination?

☐ Yes ☐ No Date Passing Score Achieved: ____________ MM/DD/YYYY

C. Provide your OE Tracker number: ______________________________

6. 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: ______________________________

7. DISCIPLINE HISTORY

A. Have you ever been denied the right to take an Optometry Licensure Examination? ☐ Yes ☐ No

B. Have you ever had any professional license or license to practice revoked, suspended, or any other disciplinary action taken? ☐ Yes ☐ No

C. Have you ever been refused a license to practice optometry or any other license or the renewal thereof? ☐ Yes ☐ No

D. Is there currently pending against you, in any jurisdiction, a complaint against your professional conduct or competence as an optometrist or any other license? ☐ 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. ☐ 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: ______________________________

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 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.

10. 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: ______________
MM/DD/YYYY

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.