Application for Licensure as a Certified Optometrist

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

DH-MQA 1128, 7/2020, Rule 64B13-4.004, F.A.C.

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

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	Application Fee (non-refundable) $250.00
Initial Licensure Fee (refundable) $300.00	Duplicate License Fee (refundable) $25.00
Unlicensed Activity Fee (refundable) $5.00	

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

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 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), Florida Statutes (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

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 (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	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: _____
MM/DD/YYYY MM/DD/YYYY

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 you responded "Yes," provide the following information:

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 (MM/DD/YYYY)	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 (MM/DD/YYYY)

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 within 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

If you responded "Yes," provide the following: Date Passing Score Achieved: _____
MM/DD/YYYY

C. Provide your OE Tracker number: _____

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 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.

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," 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 chapter (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 10 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 5 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 to the address listed on the first page of the application.

Supporting documentation including court dispositions or agency orders where applicable.

Documentation for sections 6, 7, 8 and 9 must be submitted to:

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

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 s. 456.067 and 775.083, 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 Signature _____ Date _____
You may print this application and sign it or sign digitally. MM/DD/YYYY

Complete verifications must be mailed directly from the licensing 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 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.