Department of Health

Board of Opticianry

Application for Licensure Examination

Department of Health
Florida Board of Opticianry
4052 Bald Cypress Way, C-08
Tallahassee, FL 32399-3258
Telephone: (850) 245-4474
www.floridasopticianry.gov
Email: MQA.Opticianry@flhealth.gov

Opticianry Application for Licensure Examination Instructions

Applicants are strongly encouraged to review the licensure requirements in Section 484.007, Florida Statutes, and Rule Chapter 64B12-9, Florida Administrative Code, prior to submitting this application.

Requirements to be Certified Eligible to Take the Licensure Examination

- Completion of Opticianry Application for Licensure Examination;
- Payment of $100.00 application fee, which is non-refundable;
- Not less than 18 years of age;
- Graduate of an accredited High School or possesses a certificate of equivalency of a high school education;
- Passing score on the National Opticianry Competency Examination within three years of application or current ABO certification*;
- Passing score on the Contact Lens Registry Examination within three years of application or current NCLE certification*; **and**
- Meet one of the following:
  1. Has received an associate degree in opticianry from an accredited school;
  2. Is licensed in another state and has actively practiced in that state for at least three of the last five years;
  3. Practiced in a state in which licensure is not required for at least five of the last seven years; **or**
  4. Registered as an apprentice with the Florida Department of Health and completed 6,240 hours of training under a registered sponsor within five years after the date of registration.

* The American Board of Opticianry (ABO) and the National Contact Lens Examiners (NCLE) may be reached at 1-800-296-1379 and their website is www.abo-ncle.org.

The fee must accompany the application. Please make the check or money order payable to the Department of Health. Mail the application, fee, and supporting documentation to:

Board of Opticianry
P. O. BOX 6330
Tallahassee, FL 32314-6330

Any supporting documentation mailed separately from the application should be mailed to:

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

Pursuant to section 456.013(1)(a), Florida Statutes, an incomplete application shall expire one year after initial filing with the department.

Within 30 days of receipt of your application, you will receive a status letter. If you have met the requirements for the examination, you will receive information on how to register to sit for the examination. If you have not met the requirements for the examination, you will be advised of your deficiencies.

Exam Review Course: The Board of Opticianry does **not** offer an examination review course. Furthermore, there are **no** examination review courses that are endorsed by the Board of Opticianry.

Address Change: If your address changes, you must provide written notification to the board office. Include your full name, old address, new address, and whether this is your mailing and/or your practice location address.

Name Change: If you have a legal name change, you must provide signed, written notification to the board office. Include your full name as you applied, your new full name, and a photocopy of the applicable legal document. Your name cannot be changed without valid legal documentation.

Social Security Number: Your Social Security number is required.

Licensee Information on the Internet: When you become licensed your name, license number and practice location address will be available through our Internet License Verification. All documents, including your license, will be sent to your mailing address. Your practice location address will be printed on your license and will show as your address of record on our Website, which provides the public with information on licensed health care practitioners in the State of Florida. If you only provide one address, it will be used for both the mailing address and the practice location address.
NOTE: Your practice location address must be a street address.

License/Certificate/Registration Verification: This form is required **only if** you hold or have ever held a license, certificate, or registration in any state or U.S. territory. You must mail this form to each agency that issued you a license, certificate, or registration. That agency must complete the form and mail the form directly to the board office. It will not be considered official if the verification form is received from the applicant.

Documents in a Foreign Language: A certified translator, who is not related to the applicant, must translate any document that is in a language other than ENGLISH.

Requirements for Licensure as an Optician

- Successful completion of all parts of the examination for Florida licensure;
- Copy of the certificate documenting successful completion of a two-hour laws and rules course by a Board approved laws and rules course provider;
- Copy of the certificate documenting successful completion of a two-hour live technical practice continuing education course on fitting and adjusting by a Board approved provider;
- No discovery of disqualifying factors prior to licensure;
- Payment of the initial licensure fee within one (1) year of notification of successful passage of the examination for Florida licensure; **and**
- Completion of the Initial Licensure Form, see last page of this application packet.

All licensees are responsible for knowing the laws and rules that regulate their profession. The laws in Chapter 484, Part I, Florida Statutes (F.S.), are directly related to the profession of Opticianry, and Chapter 456, F.S., governs all health care professions licensed by the Department of Health. The rules in 64B12, Florida Administrative Code (F.A.C.), govern the profession of Opticianry. The rules in 64B29, F.A.C., govern optical establishments. The laws and rules are accessible at the Opticianry Website at www.floridasopticianry.gov and click on "Resources."

COMPLETING THE APPLICATION

Print neatly in black ballpoint pen or type all information. To eliminate mailing time and expedite your application, you may apply online at www.flhealthsource.gov.

Section I. Applicant Profile Data: List your full legal name as it should appear on your license.

Section II. Education: Provide a photocopy of your high school diploma or equivalency certificate.

Section III. Eligibility Data: Indicate your method of application and provide the appropriate documentation.

- **Apprenticeship:** Please provide your apprentice (DA) number or a copy of your apprenticeship completion letter;
- **Associate Degree in Opticianry**: You must request an official transcript be sent from the accredited institution where you received your associate's degree directly to the board office or it will not be considered official. The transcript must show that the degree was awarded;
- **Licensed and Actively Practiced in Another State, Territory, or Jurisdiction of the United States for Three (3) of the Last Five (5) Years**: The License/Certificate/Registration Verification form must be completed by the state(s) in which you **hold or** have ever held a license, certificate, or registration. This form must be completed and sent directly to us from the agency which issued the license, certificate, or registration, or it will not be considered official; **or**
- **Actively Practiced in Another State, Territory, or Jurisdiction of the United States for Five (5) of the Last Seven (7) Years:** If you practiced in a state that does not require a license, please provide tax records, business records, affidavits, or other satisfactory documentation showing proof of the practice of Opticianry.

Section IV. Applicant Licensure Status: A License/Certificate/Registration Verification form is required from each state or U.S. territory where you hold or have ever held a license, certificate, or registration to practice Opticianry.

Section V. Professional Experience: Starting with the most recent, list all Opticianry work experience. Do not leave any blanks or lapses in time. If you were unemployed or not working in an optical setting, these should also be listed.

Section VI. Applicant History-Professional: If you answer "yes" to any question(s) in this section, you must provide the board complete details.

Section VII. Applicant History-General: If you answer "yes" to the history question in this section, you must explain in detail on a separate sheet of paper. In your explanation, include dates, jurisdictions, offenses, specific circumstances, and dispositions. You **must** include a certified copy of the disposition(s).

Section VIII. Applicant History - Pursuant to Section 456.0635(2), Florida Statutes:
If you answer "yes" to one or more of these questions, you must provide supporting documentation, which includes court dispositions, termination of probation, and agency orders where applicable.

Section IX. Applicant Statement: Read this entire section then sign and date. Your original signature is required.

Section X. Social Security Number: Your Social Security Number is required.

Section XI. Applicant History – Health: The Board reviews each applicant's history to determine that the applicant is able to practice the profession with reasonable skill and competence. If you have a history of serious, chronic, or recent mental health problems or addiction to drugs, you must submit a current mental health status report. Mental health status reports must come from a licensed mental health professional, with which you have no personal or professional relationship, wherein this professional opines that you are able to practice with reasonable skill and safety to patients or clients.

Florida Department of Health	Opticianry Application For Licensure Examination (2001)

DO NOT WRITE IN THIS SPACE
FOR OFFICE USE ONLY

I. APPLICANT PROFILE DATA *(PLEASE TYPE OR PRINT IN BLACK INK)*

Name	Last	First	Middle
Mailing Address	No. and Street .		Apt. No.
	City	State	Zip Code
* Practice Location Address	No. and Street		
	City	State	Zip Code

Date of Birth: ____/____/______

Sex: ☐ Male ☐ Female

Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name?
☐YES ☐NO If "YES", list the name(s):

____

Home Telephone: Area Code ( )	Business Telephone: Area Code ( )	Fax Number: Area Code ( )

E-Mail Address (Optional. Will be public record if provided.):

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 FR 38295 (8/25/78). This information is gathered for statistical purposes only and does not in any way affect your candidacy for licensure.
RACE: ☐ White ☐ Black ☐ Asian/Pacific ☐ Hispanic ☐ Other ______________

II. EDUCATION

Name & Address of High School ______________________________
Received: ☐Diploma ☐GED Date Completed: ______________
Name & Address of Optical School (if any) ______________________________

III. ELIGIBILITY DATA

Indicate the method by which you qualify for the Opticianry Examination:
- ☐ Completed the Apprenticeship Program / Registered Apprentice Number DA ________
- ☐ Associate Degree in Opticianry. Name of the School ______________________________
- ☐ Licensed by examination in another state, territory, or jurisdiction of the United States.
- ☐ Practiced over five years in another state, territory, or jurisdiction of the United States in which licensure is not required.

* Your Practice Location Address will show on our Internet License Verification, which provides the public with information on licensed health care practitioners in the State of Florida. If you only provide one address, it will be used for both the mailing address and the practice location address.
Please note that your practice location address must be a street address.

IV. APPLICANT LICENSURE STATUS

Do you hold or have you ever held a license, certificate, or registration to practice Opticianry in any state (including Florida), territory, or jurisdiction of the United States, or foreign country? ☐ YES ☐ NO

If YES, list all licenses, certificates, and/or registrations and the issuing state, territory, or foreign country. Each issuing state, territory, or foreign country must submit a license/certificate/registration verification form.

TYPE OF LICENSE/CERTIFICATE	ISSUING STATE, TERRITORY, FOREIGN COUNTRY

V. PROFESSIONAL EXPERIENCE

Starting with the most recent experience, list below all work experience. Attach additional sheets if necessary.

Dates of Experience From M/D/Y To M/D/Y Explain all breaks in experience	Place of Employment and Address (actual location where you worked)	Duties Performed
1. ______	1. ______	1. ______
2. ______	2. ______	2. ______
3. ______	3. ______	3. ______
4. ______	4. ______	4. ______
5. ______	5. ______	5. ______
6. ______	6. ______	6. ______
7. ______	7. ______	7. ______
8. ______	8. ______	8. ______

VI. APPLICANT HISTORY – PROFESSIONAL

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:	
	1. Acts of dishonesty, fraud, or deceit	1.❑YES ❑NO
	2. Lying on a resume or misrepresentation	2.❑YES ❑NO
	3. Academic misconduct, including acts such as cheating or plagiarism	3.❑YES ❑NO
	4. Theft	4.❑YES ❑NO
	5. Sexual harassment	5.❑YES ❑NO

If you answered "YES" to any question in Section VI, you must provide the board complete details.

VII. APPLICANT HISTORY – GENERAL

Have you ever been convicted of, or entered a plea of guilty or nolo contendere (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 by the court so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. ❑ YES ❑ NO

If you answer YES, you must explain in detail on a separate sheet of paper. In your explanation, include dates, jurisdictions, offenses, specific circumstances, and dispositions.

You **must** include a certified copy of the court records/dispositions.

VIII. APPLICANT HISTORY - Pursuant to Section 456.0635(2), Florida Statutes,

IMPORTANT NOTICE: Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide 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. Supporting documentation includes court dispositions or agency orders where applicable.

	Question	Answer
1.	Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, 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? (If you responded "no", skip to # 2.)	❑ YES ❑ NO
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 or conviction, and completion of any sentence or subsequent period of 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 any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes.)	❑ YES ❑ NO
c.	If "yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, 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", 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, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? (If "No", do not answer 2a)	❑ YES ❑ NO
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, Florida Statutes? (If "No", do not answer 3a.)	❑ YES ❑ NO
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? (If "No", do not answer 4a or 4b.)	❑ YES ❑ NO
a.	Have you been in good standing with a state Medicaid program for the most recent five years?	❑ YES ❑ NO
b.	Did the 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 Inspector General's List of Excluded Individuals and Entities?	❑ YES ❑ NO

IX. APPLICANT STATEMENT

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past or present), business and professional associates (past or present), and all government agencies and instrumentalities (local, state, federal, or foreign) to release to the Department of Health any information, files, or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organizations, individuals, and groups listed above any information which is material to my application.

I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board's decision concerning my eligibility for examination or licensure. Such supplement is required by s. 456.072, F.S., and 456.013(1)(a), F.S. Failure to do so may result in disciplinary action by the Board including denial of licensure.

I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind. I declare that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to s. 456.067, F.S., or criminal penalties pursuant to s. 775.082, s. 775.083, or s. 775.085, F.S. Should I furnish any false information on this application, I hereby acknowledge that such act may constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida.

The practice of Opticianry in Florida is governed by Chapters 456 and 484, Part I, Florida Statutes, and Chapter 64B12, Florida Administrative Code, 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, Florida Administrative Code.

I understand that pursuant to s. 456.013(1)(a), F.S., an incomplete application shall expire 1 year after initial filing.

I further state that I will comply with all requirements for licensure renewal, including continuing education credits.

______________________________ Applicant's Signature

____________________ Date

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Florida Department of Health

Board of Opticianry

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013(1)(a), Florida Statutes.

Name: ____

Last **First** **Middle**

X. SOCIAL SECURITY NUMBER: ______________________	
XI. APPLICANT HISTORY – HEALTH	
A. Do you have any condition that currently impairs your ability to practice your profession with reasonable skill and safety?	❑ YES ❑ NO
B. 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 answered "yes" to either of the above questions, please provide 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 stating either that you are safe to practice your profession without restriction or indicating what restrictions are necessary. If necessary, you may attach additional sheets. Documentation must be current within the last year. If you fail to disclose the information requested in this section, your application may be denied.

Florida Board of Opticianry

LICENSE/CERTIFICATE/REGISTRATION VERIFICATION FORM

I am applying for licensure in the State of Florida. The Florida Board of Opticianry requires verification of licensure by each jurisdiction in which I hold or have ever held a license. Please complete Part II and return to the Florida Board of Opticianry at the address below.

PART I: TO BE COMPLETED BY THE APPLICANT.

Complete this part and submit to each state where you hold or have ever held a license to practice Opticianry.

Applicant Name (please print): ____

Address/City/State/Zip: ____

License/Certificate Number: ____________________ State of: ____________________

Applicant's Signature ______________________________ Date: ____________________

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PART II: TO BE COMPLETED BY AN OFFICIAL OF THE REGULATORY BOARD AND RETURNED TO THE ADDRESS BELOW

Licensee's Name: ______________________________ Profession: ____________________

License/Certificate Number: ____________________ Original Issue Date: ______________

License/Certification Status: ____________________ Expiration Date: ______________

Is there any time period when this license was not active for any reason? ☐ YES ☐ NO

If Yes, please list the beginning and ending dates of non-active periods and the reasons.

____

____

Do you have any disciplinary action information on file regarding this licensee? ☐ YES ☐ NO

If this license was ever revoked, suspended or otherwise acted against, please provide a copy of the action(s) with this form when it is returned.

Board/State Seal

Verified by: ______________________________

Signature of Official

____

Printed Name and Title

____

Name of State Date Signed

Please return this form to:

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

Rule 64B12-9.0015, F.A.C.
Form DH-MQA 1065, (Revised 11/18)

EXAMINATION APPLICATION CHECKLIST

The following items must be received in order for your application to be complete:

MAILED BY THE APPLICANT:

_____ Completed and signed application

_____ Check or money order in the amount of $100.00

_____ Photocopy of current ABO certification or proof of passing the ABO examination within three years of application

_____ Photocopy of current NCLE certification or proof of passing the NCLE examination within three years of application

_____ Photocopy of High School diploma or equivalency

_____ Detailed explanation and required documentation for any "Yes" answers to history questions

_____ Documentation showing proof of five years Opticianry practice within the last 7 years, if you are qualifying by this method

MAILED BY THE ORIGINATING SOURCE:

_____ License/Certificate/Registration Verification Form from each state where you hold or have ever held a license, certificate, or registration

_____ Official transcript showing Associate Degree in Opticianry was awarded, if you are qualifying by this method

INITIAL LICENSURE FORM
OPTICIANRY (2001)

Do not write in this space

Please Note: According to Rule 64B12-9.0015(5), Florida Administrative Code, the initial licensure fee **must** be paid within one year of notification of successful passage of the examination.

To receive your initial license, please complete and return this form with a check or money order made payable to the Department of Health for the initial licensure fee. The licensure biennium ends on December 31 of every even-numbered year. Please determine the correct amount of your initial licensure fee from the following information:

- **If you submit the fee in an odd-numbered year, the initial licensure fee is $130.00 and you will be required to renew your license by December 31 of the following year.**
- **If you submit the fee between January 1 and August 1 of an even-numbered year, the initial licensure fee is $67.50 and you will be required to renew your license by December 31 of the same year.**
- **If you submit the fee after August 1 of an even-numbered year, the initial licensure fee is $130.00 and you will be required to renew your license by December 31 of the next even-numbered year.**

NAME (PRINT NEATLY OR TYPE ALL INFORMATION) ______________________________

LAST FOUR DIGITS OF YOUR SOCIAL SECURITY NUMBER ____________

MAILING ADDRESS ______________________________

LOCATION ADDRESS ______________________________

☐ CHECK THIS BOX IF YOUR MAILING OR LOCATION ADDRESS HAS CHANGED.

Please return this form with a check or money order to:

Board of Opticianry
P.O. Box 6330
Tallahassee, Florida 32314-6330

Rule 64B12-9.0015, F.A.C.
Form DH-MQA 1065, (Revised 11/18)