Optician Application for Examination

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

Optician Application for Examination

Board of Opticianry
P.O. Box 6330
Tallahassee, FL 32314-6330
Fax: (850) 921-5389
Email: info@floridasopticianry.gov

Do Not Write in this Space
For Revenue Receipting Only

Important: ALL applicants must be at least 18 years of age.

Licensure Examination (2001) **$100.00**

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Application fees are 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 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 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 Hispanic or Latino White 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 (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), 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. ELIGIBILITY DATA

Indicate the method by which you qualify to sit for the Opticianry Examination. Select only one:	
☐ Apprenticeship Program	☐ Associate Degree in Opticianry or equivalent
☐ Licensed by examination in another state/territory/jurisdiction	☐ Actively practiced in another state/territory/jurisdiction where licensure is not required

Provide the requested information/documentation only in the section below that corresponds to the method by which you qualify.

☐ **Apprenticeship Program**

A. Did you complete 6,240 hours of training under a registered sponsor within five years after the date of your registration with the Florida Department of Health? Yes No

B. Provide your Registered Apprentice Number: **DA** ____________________
If Registered Apprentice Number cannot be provided, submit a copy of your apprenticeship completion letter.

☐ **Associate Degree in Opticianry or Equivalent**

A. Have you received an associate degree in opticianry or equivalent from an accredited school?
Yes No

B. Provide the following about the institution where you received your degree:

School Name	City/State or Country	Dates of Attendance: From-To (MM/DD/YYYY)	Degree Awarded
		to	
		to	

Transcripts must be sent in the official sealed envelope directly from the university. Send by mail or via electronic secure transfer to MQA.Opticianry@flhealth.gov. Diplomas and student copies are not acceptable.

☐ **Licensed by examination in another state/territory/jurisdiction** (of the United States and actively practiced in that state for at least three of the last five years)

A. List the **active opticianry license** from the state(s) in which you have actively practiced for three of the last five years.

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 **each** state in which you hold an **active license** in opticianry. License verifications must be received directly from the licensing authority. **A copy of your license will not be accepted** in lieu of official verification from the licensing agency.

☐ **Actively practiced in another state/territory/jurisdiction** (of the United States in which licensure is not required, for at least five of the last seven years.)

☐ If you practiced opticianry in a state that does not require a license, **provide tax records or business records, and an affidavit** showing proof of at least five years of opticianry practice within the last seven years.

All eligibility documentation should be submitted directly to the board office at:

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

Name: ____

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

C. List all health-related licenses (active, inactive or lapsed), unless provided on page 4.

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. **A copy of your license will not be accepted** in lieu of official verification from the licensing agency.

D. Starting with the most recent, list all opticianry work experience, employment outside of an optical setting, or any other unaccounted period of time. Do not leave any blanks or lapses in time. Attach additional sheets if necessary.

Name of Business	Full Mailing Address	Employment Dates: From-To (MM/DD/YYYY)
		to

Duties Performed: ____

____

Name of Business	Full Mailing Address	Employment Dates: From-To (MM/DD/YYYY)
		to

Duties Performed: ____

____

Name of Business	Full Mailing Address	Employment Dates: From-To (MM/DD/YYYY)
		to

Duties Performed: ____

____

Name: ______________________________

5. DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? ☐ Yes ☐ No

6. EDUCATION HISTORY

A. Have you earned a high school diploma or equivalent? ☐ Yes ☐ No

B. Provide the following information about your high school or equivalent:

School Name	School Address	Graduation Date (MM/DD/YYYY)	Degree Awarded
			☐ Diploma ☐ GED

☐ **Include a photocopy of your high school diploma or equivalency certificate.**

7. EXAMINATION/CERTIFICATION HISTORY

Applicants must have successfully completed a national opticianry competency examination.

Select the examination completed and ***attach proof of completion***:	
☐	National Opticianry Competency Examination developed by the American Board of Opticianry (ABO)
☐	Basic Spectacles Examination developed by the National Commission of State Opticianry Regulatory Boards (NCSORB)

Applicants must have successfully completed a national contact lens examination.

Select the examination completed and ***attach proof of completion***:	
☐	Contact Lens Registry Examination developed by the National Contact Lens Examiners (NCLE)
☐	Basic Contact Lens Examination developed by NCSORB

Applicants must have successfully completed all required examinations <u>within the three years immediately preceding</u> the submission of the application for licensure. For applications submitted more than three years after successful completion of the examinations, applicants may submit a current national certification and proof that they have continued to maintain a current national certification by completing continuing education courses.

For more information about the above examinations, you may contact:

Organization	Website	Telephone #
ABO	www.abo-ncle.org	800-296-1379
NCSORB	https://ncsorb.org	855-208-9349

The Board of Opticianry does <u>not</u> offer an examination review course, nor does it endorse any.

Supporting documentation not submitted with the application may be submitted electronically to MQA.Opticianry@flhealth.gov or mailed directly to the board office at:

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

Name: ____

This information is exempt from public records disclosure.

8. 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: ______________________________

9. 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 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 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**.

10. 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: ____

11. 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 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 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.

Documentation for sections 8, 9, 10, and 11 must be mailed to:

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

Documentation submitted to the board must be in English. Any documents in a language other than English must be translated by a certified translator, who is not related to the applicant.

12. 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.

The practice of opticianry in Florida is governed by ch. 456 and 484, Part I, F.S., and ch. 64B12, Florida Administrative Code (F.A.C.), which I state I have read and understand. I understand that it is my responsibility to keep informed of any changes to ch. 456 and 484, Part I, F.S., and ch. 64B12, F.A.C.

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:

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

Florida Board *of* Opticianry 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 Opticianry.

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.