APPLICATION FOR LICENSURE
AS CERTIFIED OPTOMETRIST
PLEASE READ CAREFULLY

FLORIDA LAWS & RULES:

You may download a copy of Chapter 463, Florida Statutes and Rule Title 64B13, Florida Administrative Code at www.floridaoptometry.gov/resources It is important to read this in order to determine your eligibility prior to applying, and tc familiarize yourself with the statutes and board rules regarding your application for licensure and the practice of the optometric profession within the State of Florida.

APPLICANT'S QUESTIONS REGARDING APPLICATION STATUS:

Within thirty (30) days after we receive your application and fee, we will send you an acknowledgment letter informing you of any deficiencies in your application and the specific items required to complete your application. If you do not receive notice that we have received your application within forty-five (45) days of the date you mailed it, or if you have questions concerning the requirements for licensure, please do not hesitate to contact this office. If you have questions concerning whether or not we have received items which we require you to arrange to be sent to this office by a third party (such as official transcripts, licensure verifications from state licensing agencies); please check with the third party first to see if the required documentation has been sent. As a reminder to all applicants, Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YES/NO QUESTIONS:

All questions with a "Yes or No" answer must be marked with either a "Yes" or "No" as no other response is acceptable. For questions which require a brief explanation or description to "Yes" answers, your responses must be sufficiently detailed to ascertain the **relevant dates**, institution/organization names, and a brief synopsis of the reasons (i.e., the final charges or substantiated allegations only) the institution/organization took the disciplinary or other action (i.e., probation, limitation, suspension, revocation, voluntary relinquishment in lieu of disciplinary action, or any other adverse action). HOWEVER, IF A QUESTION CONTAINED IN THIS APPLICATION IS NOT APPLICABLE ANSWER "N/A" IN THE NO COLUMN. **Certified or notarized documentation of final disposition to "yes" answers is required.**

FEES:

OPTOMETRY LICENSURE EXAMINATION:

Application Fee:		$ 250.00
Initial Licensure Fee:		$ 300.00
Unlicensed Activity Fee:		$ 5.00
Department Administrative Costs*:	Laws & Rules	$ 100.00
TOTAL FEE:		**$ 655.00**

*See Rule **64B-1.016** **Fees: Examination and Post-Examination Review** – The fees cover administrative costs, actual per-applicant costs, and costs incurred to develop, purchase, validate, administer, and defend department developed, administered, or managed examinations.

RE-EXAMINATION FEES:

Laws/Rules Examination Fee	$ 100.00

UPGRADE OPTOMETRIST TO CERTIFIED OPTOMETRIST - ONLY: (Non-Certified Optometry only)

Application Fee:	$ 250.00
Duplicate License Fee:	$ 25.00
TOTAL FEE:	**$ 275.00**

REQUIRED EXAMINATION INFORMATION:

Florida Laws and Rules (CBT)

National Board of Examiners in Optometry (NBEO): Official NBEO Scores for parts **I (ABS), II (PAM – which includes the TMOD) and III (specifically Biomicroscopy, Binocular Indirect Ophthalmoscopy and Dilated Biomicroscopy and Non-Contact Fundus Lens Evaluation skills)**

SPECIAL TESTING ACCOMMODATIONS:

Special Testing Accommodations Due to Disability: Rules regarding examination procedures for candidates with disabilities are outlined in Rule 64B-1.005, F.A.C. In accordance with Rule 64B-1.005, F.A.C., the Department will provide reasonable and appropriate special testing accommodations to candidates with physical or learning disabilities to the extent permitted by cost, examination administration constraints, examination security considerations and availability of resources. Candidates requesting special testing accommodations must file a completed application with Practitioner Reporting & Examination Services. It is the responsibility of the candidate to provide adequate documentation of his/her disability.

Requests from Candidates Previously Receiving Special Testing Accommodations: Applicants who have previously received special testing accommodations for an examination and need accommodation for another examination or for a retake of the same examination in Florida must file a reapplication with Practitioner Reporting & Examination Services, Bureau of Operations each time accommodation is needed.

PREVENTION OF MEDICAL ERRORS:

A two hour course on the prevention of medical errors is required for licensure. Please refer to CEBroker's website at www.cebroker.com and click the Florida Course Search quick link for a list of approved courses.

OPTOMETRY COLLEGE TRANSCRIPT:

A final official transcript stating the degree and date of confirmation must be sent directly from the optometry school/college to this office. Transcripts submitted by the applicant or indicating "issued to student" are not acceptable. A copy of your diploma is not acceptable. Please note that it is your responsibility to follow-up with your educational institutions to ensure that they have received and complied with your requests.

LICENSURE VERIFICATION:

The licensure verification forms included with this application package must be sent to each state or other licensing authority where you currently hold or have held a license to practice, regardless of the status of the license. These forms must be sent directly from each state licensing agency to this office. Please note that it is your responsibility to follow-up with licensing agencies to ensure that they have received and complied with your requests. **A copy of your license will not be accepted in lieu of official verification from the licensing agency.**

NATIONAL BOARD OF EXAMINERS IN OPTOMETRY (NBEO) SCORES:

Official NBEO Scores for parts **I (ABS), II (PAM – which includes the TMOD) and III** must be sent directly from National Board to this office. Again, please note that it is your responsibility to follow-up with NBEO to ensure that they have received and complied with your requests.

OE TRACKER NUMBER: Please provide this number during your application process.

FOREIGN EDUCATION EQUIVALENCY REQUIREMENTS:

All foreign graduates who intend to utilize credit earned in colleges or universities outside of the United States to qualify for licensure will need to provide evidence of U. S. equivalency of such credit hours. The credentials evaluation must be performed by one of the acceptable credential evaluation services and include a breakdown of all college level courses by subject. Credit hours must be listed in semester hours. The credentials evaluation should be sent directly to the board office from the evaluator. If transcripts cannot be ordered from the foreign institution, certified copies of the original documents used in the evaluation must be submitted to the agency.

ACCEPTABLE FOREIGN CREDENTIALS EVALUATION SERVICES:

1. JOSEF SILNY & ASSOCIATES
   INTERNATIONAL EDUCATIONAL
   CONSULTANTS
   7101 SW 102 AVENUE
   MIAMI, FL 33173
   PHONE: (305) 273-1616
   FAX: (305) 273-1338

2. FOUNDATION FOR INTERNATIONAL
   SERVICES, INC.
   14926 35th AVENUE WEST, SUITE 210
   LYNWOOD, WA 98087
   PHONE: (425) 248-2262
   FAX: (425)248-2262
   www.fis-web.com

3. EDUCATION CREDENTIAL EVALUATORS, INC.
P. O. BOX 92970
MILWAUKEE, WI 53202-0970
PHONE: (414) 289-3400
FAX: (414) 289-3411

4. CENTER FOR APPLIED RESEARCH, EVALUATION & EDUCATION, INC.
P.O. BOX 18358
ANAHEIM, CA 92817
PHONE: (714) 237-9272
FAX: (714) 237-9279

5. INTERNATIONAL EDUCATION RESEARCH FOUNDATION, INC.
P. O. BOX 3665
CULVER CITY, CA 90231
PHONE: (310) 258-9451
FAX: (310) 342-7086

6. WORLD EDUCATION SERVICES, INC.
P.O. BOX 01-5060
MIAMI, FL 33101
PHONE: (305) 358-6688
www.wes.org

7. FOREIGN ACADEMIC CREDENTIALS SERVICES, INC.
P. O. BOX 400
GLEN CARBON, IL 62034
PHONE: (618) 307-6036
(618) 656-5291
FAX: (618) 656-5292

8. WORLD EDUCATION SERVICES, INC.
BOWLING GREEN STATION
P.O. BOX 5087
NEW YORK, NY 10274-5087
PHONE: (212) 966-6311
FAX: (212) 739-6100
www.wes.org

WEB SITE: You can also visit the board's web site for additional information at www.floridaoptometry.gov

NOTE: Language interpretation services are available to applicants for licensure who have limited-English proficiency or a hearing/speech impairment. If you need an interpreter in order to talk with your application processor, please indicate that information when you call the board office. An interpreter and the processor will call you back shortly in order to handle your call.

PLEASE NOTE--YOUR APPLICATION IS NOT CONSIDERED COMPLETE UNTIL ALL SUPPORTING DOCUMENTS AND FEES HAVE BEEN RECEIVED BY THIS OFFICE.

Computer Based Test Information

Once you have received your notification of eligibility from the board office, you may contact Prometric to pay the CBT examination fee and schedule your examination.

COMPUTER BASED TEST FEES

Please Note—Fees are required in addition to the fees already submitted to the board.

Optometry Laws/Rules Fee – $58.00

This fee shall be paid to Prometric.
The fee may be paid by Visa, MasterCard, American Express, or electronic check.
Payment will be due at the time of scheduling.

SCHEDULING:

You must schedule your examination appointment with Prometric. You may contact Prometric via telephone or Internet at the contact information listed on the last page of the Candidate Information Booklet (CIB).
When contacting Prometric, you must select/state that you are taking a "Florida Department of Health" examination.
You will be required to provide your social security number (as your testing/eligibility ID) in order to schedule your examination.
All examination dates, times, and locations will be scheduled on a first-come first-serve basis.

RESCHEDULING:

You may reschedule your examination appointment as needed, without penalty, up to two days prior to your examination.

If you attempt to reschedule your examination within two days of your appointment, you will be considered a "late cancel." You must then wait at least three (3) days from the date of your appointment before you may reschedule your examination. You will be required to repay the examination fee.

One form of **valid, current, government-issued identification** with both a signature and a photo.

Driver's License; OR
State I.D. card; OR
Military I.D.; OR
Passport

NOTE: The name on your eligibility record (from your examination application submitted to the Board Office) **must match the name on the ID you present at the Prometric testing center.** If these names do not match, you will not be allowed to test. To change the name on your eligibility record, contact the Board Office.

Note: If you do not fill in your social security number, your application will be delayed. You must possess a social security number prior to receiving a license.

If the package that you are mailing to the Board Office contains money, mail to:

DEPARTMENT OF HEALTH
Post Office Box 6330
Tallahassee, Florida 32314-6330

If the package that you, or anyone on your behalf, is mailing to the Board Office does NOT contain money, mail to:

Board of Optometry
4052 Bald Cypress Way, Bin #C07
Tallahassee, Florida 32399-3257

NOTE: Language interpretation services are available to applicants for licensure who have limited-English proficiency or a hearing/speech impairment. If you need an interpreter in order to talk with your application processor, please indicate that information when you call the board office. An interpreter and the processor will call you back shortly in order to handle your call.

FEDERAL PRIVACY ACT:

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, Sections 653 and 654: and sections 456.013, 409.257(7) and 409.259(8), F. S.** Social security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to assure 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 verification pursuant to, unless exempt as outlined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L. 193, Section 317.

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Florida Department of Health
Board of Optometry

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**

Social Security Number: _____

APPLICANT HISTORY: (If you answer YES to the following questions, please provide additional sheets, the relevant dates and circumstances of such treatment and/or addiction along with the names and addresses of the medical practitioners or hospitals who performed such treatment.)

1. In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years? [ ] YES [ ] NO

2. In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment? [ ] YES [ ] NO

3. During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder or that has impaired your ability to practice within the past five years? [ ] YES [ ] NO

4. During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice? [ ] YES [ ] NO

5. In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years? [ ] YES [ ] NO

6. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug)disorder that has impaired your ability to practice within the last five years? [ ] YES [ ] NO

APPLICATION FOR LICENSURE
AS CERTIFIED OPTOMETRIST
(Client: 1801)

READ/DOWNLOAD APPLICATION INSTRUCTIONS FOR IMPORTANT INFORMATION

APPLICATION CATEGORY/APPLICABLE FEES: (TYPE OR PRINT LEGIBLY IN BLACK INK)

[ ] INITIAL EXAMINATION (1010)
- Laws/Rules **TOTAL: $655.00**

[ ] RE-EXAMINATION (1011)
- Laws/Rules **TOTAL: $100.00**

[ ] UPGRADE OPTOMETRIST TO CERTIFIED OPTOMETRY (Non-Certified Optometry only) (1030)
TOTAL: $275.00

PROFILE DATA:

1. NAME: _____
(Last) (First) (Middle)

Have you changed your name through marriage or through action of a court, or have you been known by any other name? [ ] YES [ ] NO

_____
If YES, list name(s) (Last, First, Middle) and Date(s) of changes

2. a. **MAILING ADDRESS:**

_____
(Street and Number) (Apt. Number)

_____
(City) (State) (Zip)

b. **PRACTICE LOCATION:**

_____
(Street and Number) (Apt. Number)

_____
(City) (State) (Zip)

c. **TELEPHONE: _(_____)_____** **_(_____)_____**
Primary: Area Code/Phone Number Business: Area Code/Phone Number

d. **EMAIL ADDRESS:** _____

(**Email Notification**: If you want to notified of the status of your application by email please check the **"YES"** box and write your email address on the line provided above. If you choose this form of notification you will receive information regarding your application file through email. You will be responsible for checking your email regularly and updating your email address with the board office mqa_optometry@doh.state.fl.us . Under Florida law, email addresses are public records. If you do not want your e-mail 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. [ ] YES [ ] NO

3. PERSONAL DATA:

BIRTH DATE: _____
(Month/Day/Year)

CITIZENSHIP: _____

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 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.

RACE: [ ] Caucasian [ ] African-American/Black [ ] Hispanic [ ] Asian [ ] Native American [ ] Other

SEX: [ ] Male [ ] Female

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

4. APPLICANT EDUCATION AND TRAINING DATA:

a. Optometric Education: _____
(Name of School(s) you attended)

_____

_____

b. Did you Graduate? [ ] YES [ ] NO Degree: _____ Year Graduated: _____

c, Have all parts of the National boards, which includes Clinical Pharmacology and/or T.M.O.D. been taken within the past seven years? [ ] YES [ ] NO

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 to the address below. Supporting documentation includes court dispositions or agency orders where applicable.

APPLICANT HISTORY (ATTACH ADDITIONAL SHEETS IF NECESSARY)

5. Have you been convicted of, or entered a plea of guilty or nolo contendere, 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 6)** [ ] YES [ ] NO

a. If "yes" to 5, for 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 5, for 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 5, for 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 5, 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

6. 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 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? [ ] YES [ ] NO

a. If "yes" to 6, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation of such conviction or plea ended? [ ] YES [ ] NO

7. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If "No", do not answer 7a.)** [ ] 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

8. 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 8a or 8b.)** [ ] 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 to the date of this application? [ ] YES [ ] NO

9. 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

10. If "yes" to any of the questions 5 through 9 above, on or before July 1, 2009, were you enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by this profession's licensing board or the Department of Health?
(If "yes", please provide official documentation verifying your enrollment status.) [ ] YES [ ] NO

11. Have you ever been convicted or found guilty, regardless of adjudication, of a crime in any jurisdiction, or have you ever been a defendant in a military court-martial? (Do not include parking or speeding violations) [ ] YES [ ] NO

12. Have you ever been declared legally incompetent? [ ] YES [ ] NO
If YES, please explain in full on attached sheets as to court date and circumstance and medical practitioners consulted.

13. 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

14. Have you ever been denied the right to take an Optometry Licensure Examination in any state? [ ] YES [ ] NO

15. Have you ever been refused a license to practice optometry or any other license or the renewal thereof in any state? [ ] YES [ ] NO

16. Have you had a license or certification of registration to practice optometry or any other licensed profession revoked, suspended or otherwise acted against (including probation, fine, reprimand or surrender of license) in a disciplinary proceeding in any state? [ ] YES [ ] NO

17. Is there currently pending against you, in any jurisdiction, a complaint against your professional conduct or competence as an optometrist? [ ] YES [ ] NO

18. Have you served in the Armed Forces? [ ] YES [ ] NO
If yes, Enlistment Date _____ **Separation Date** _____ **Type of Discharge** _____

19. Do you now hold or have you held a license to practice optometry in any state, US territory or foreign country? [ ] YES [ ] NO

If yes, State	**License Number**
_____	_____
_____	_____

20.

a. [ ] I am applying to take the Certified Optometrist Examination based on graduation from an approved school or college of optometry which has certified to the Board that graduates received 110 hours of approved coursework in general and ocular pharmacology, including clinical training and at least one year of supervised experience in differential diagnosis of eye diseases or disorders.

[ ]	University of Alabama	1973	[ ]	University of Missouri	1984
[ ]	University of California (Berkeley)	1977	[ ]	Southern College	1976
[ ]	Southern California College	1979	[ ]	NEWENCO	1977
[ ]	Ferris State College	1979	[ ]	Northeastern State	1983
[ ]	Pennsylvania College	1976	[ ]	Ohio State	1972
[ ]	Waterloo, Canada	1976	[ ]	Pacific University	1977
[ ]	University of Houston	1975	[ ]	Illinois College	1976
[ ]	State University of New York	1975	[ ]	Nova Southeastern	1993
[ ]	Indiana University University of	1976	[ ]	Inter-American University	1985
[ ]	Montreal Midwestern University	1983		(Puerto Rico)	
[ ]	Arizona	2013	[ ]	University of the Incarnate Word Rosenberg	2013
[ ]	Western University of Health Sciences	2013			

b. [ ] I am applying based on completion of 110 hours of transcript quality coursework and clinical training in general and ocular pharmacology.

Course Title	Sponsor	Hours Granted

21. APPLICANT SIGNATURE:

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department of Health any information, files and/or records requested by the Department in connection with the processing of this application. I further authorized the Department to release to the organization, 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 Chapter 456.072 and 456.067, Florida Statutes. Failure to do so may result in disciplinary action by the board, including the denial of licensure. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I understand that such action shall constitute cause for denial, suspension or revocation of any license to practice, in the State of Florida, the profession for which I am applying. I understand the application fees are non-refundable.

I understand that I will comply with all requirements for licensure renewal in effect at the time of license renewal including submission of appropriate renewal fees and continuing education credits. As a reminder to all applicants, please understand that Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

APPLICANT SIGNATURE: _____ DATE: _____

PREVENTION OF MEDICAL ERRORS CONTINUING EDUCATION

TO: **Florida Board of Optometry**
4052 Bald Cypress Way, Bin #C07
Tallahassee, FL 32399-3257

FROM: _____
(Please type or print)

I have completed a board approved educational course on the "Prevention of Medical Errors", as required by Florida Statutes.

I understand that these statements are true and correct. I further understand and acknowledge that providing false information may result in the denial of my application, disciplinary and/or criminal penalties as provided in Florida Statutes 456.072, 456.067, 775.082, 775.083, or 775.084.

_____
COURSE TITLE

_____
DATE COURSE COMPLETED

_____
Signature (Required)

_____
Date (of signature)

LICENSE VERIFICATION

INSTRUCTIONS TO THE APPLICANT:
1. Complete the information in Part I only.
2. This form must be returned by the state Board or agency which issued your license.

PART I: TO BE COMPLETED BY APPLICANT

Name**:**_____ DOB:___/___/_____

Address:_____

Title of License:_____ License No.:_____

PART II: TO BE COMPLETED BY THE STATE BOARD OFFICE

The individual listed above has applied for licensure in Florida as a Doctor of Optometry. Before further consideration is given to this application, we require the information requested on this form. The Board may submit their standard verification form in lieu of completing this form, as long as you indicate whether or not discipline has been taken against the license, and affix the Board seal. **Please return the requested information to: Florida Board of Optometry, 4052 Bald Cypress Way, Bin #C07, Tallahassee, Florida 32399-3257**

Name:_____
Title of License:_____
Original Issue Date:_____
License Number:_____
State:_____

THIS LICENSE IS CURRENTLY:
[ ]Active [ ]Inactive [ ]Temporary [ ]Other (Explain)

THIS LICENSE WAS OBTAINED BY:
[ ]Examination [ ]Grandfathering [ ]Reciprocity/Endorsement

ACTION TAKEN AGAINST LICENSE:
[ ]No Disciplinary Action Taken [ ]Disciplinary Action Taken*****

Signature:_____ Title:_____

Date:_____ State Board:_____ **Please Affix Board Seal**

*** If disciplinary action has been taken against this licensee, please provide certified copies of documentation regarding any disciplinary actions directly to the Florida Board of Optometry.**

APPLICATION REQUEST FOR
OPTOMETRY SPECIAL TESTING ACCOMMODATION
TESTING ACCOMMODATIONS

To apply for special testing accommodations you may:

1) mail this request to our office and an application will be mailed to you;
2) fax this request to our office at (850) 487-9537 and an application will be mailed to you or
3) visit our website at www.doh.state.fl.us to download the application.

This form is not an application for special testing accommodations. Please mail the application to the address below. The Department or its testing provider will make the arrangements for special testing accommodations only if your application is approved.

Please print or type the following information.

Name_____

Address_____

_____

Telephone Number (W) ( )_____**(H) ( )**_____

Profession for which you are requesting testing accommodations for: _____

Disability Request? _____Yes _____No

Religious Conflict Request? _____Yes _____No

English as Second Language _____Yes _____No (Not an option for all professions)

Have you received special testing accommodations for the State of Florida before? ____Yes ____No

RETURN THIS FORM TO:

Department of Health
Bureau of Operations, Practitioner Reporting & Examination Services
ATTN: Special Testing Coordinator
4052 Bald Cypress Way, Bin #C90
Tallahassee, FL 32399-3260
(850) 245-4252 Phone (850)
487-9537 FAX
(Do not send this request to the Board Office)