Optician Application for Examination

Board *of* Opticianry
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: floridasopticianry.gov
Email: MQA.Opticianry@flhealth.gov
Phone: (850) 245-4474
Fax: (850) 921-5389

DH-MQA 1065, Revised 12/2024, Rule 64B12-9.0015, F.A.C.

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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**

Indicate the method which qualifies you to sit for the Opticianry Examination. Select only one:

Apprenticeship Program Associate Degree in Opticianry or equivalent

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

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

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; American Indian or Alaska Native; Two or More Races; Hispanic or Latino; Black or African American; White; Asian

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE (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, authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

U.S. Social Security Number: _____

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, Florida Statutes. 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 which qualifies you to sit for the Opticianry Examination. Select only one:	
Apprenticeship Program	Associate Degree in Opticianry or equivalent

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 a 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 information about the institution where you received your degree:

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

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

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

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).

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

Staff will attempt to complete verifications online. If unavailable online or if the online verification lacks sufficient detail, you will be required to request an official verification from your state. 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.

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: _____

5. AVAILABILITY FOR 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

If you respond "Yes," your name will be added to a listing that is available to the Department of Health if a disaster is declared. If you live in an area where you may be able to help you will be called on if needed.

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:	**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:	
	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)

Include proof of completion of the national opticianry competency examination.

Applicants must have successfully completed a national contact lens examination.

Select the examination completed:	
	Contact Lens Registry Examination developed by the National Contact Lens Examiners (NCLE)
	Basic Contact Lens Examination developed by NCSORB

Include proof of completion of the national contact lens examination.

Applicants must have successfully completed all required examinations within the three years immediately preceding 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 not 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

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

For the question below, you **must include** all misdemeanors and felonies, even if adjudication was withheld. Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are **not** minor traffic offenses for purposes of this question. Pursuant to s. 943.0585(6)(b), Florida Statutes, and s. 943.059(6)(b), Florida Statutes, an applicant seeking to be licensed by the Department of Health must disclose expunged and sealed criminal history records.

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? 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), Florida Statutes.

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, Florida Statutes (relating to social and economic assistance), ch. 817, Florida Statutes (relating to fraudulent practices), ch. 893, Florida Statutes (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), Florida Statutes)? Yes No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), Florida Statutes, 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, 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

   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, Florida Statutes? 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

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, Florida Statutes.

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, Florida Statutes, 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, Florida Statutes, and ch. 64B12, F.A.C.

Section 456.013(1)(a), Florida Statutes, 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.