Optician Application for Board Certification

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

DH-MQA 1194, Revised 5/2025, Rule 64B12-14.002, F.A.C.

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P.O. Box 6330
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Do Not Write in this Space For Revenue Receipting Only

A board-certified optician may independently fill, fit, adapt, or dispense soft contact lenses.

Board Certification **$50.00**

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~~ip~~ 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~~ip~~ 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 ~~Section~~ 60-3-Uniform Guidelines on Employee Selection Procedure (1978) 43 ~~C~~FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

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

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

Yes No Email Address: _____

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

2. SOCIAL SECURITY DISCLOSURE (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: _____

~~(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, 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.

3. APPLICANT BACKGROUND

A. List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.

_____

To be eligible for certification, applicants must hold a valid/current license to practice as an optician in the state of Florida.

B. Provide your Florida Optician License #: **DO**_____

Is this license active? Yes No

4. EDUCATION HISTORY

To be eligible for certification, applicants must have completed a 20-hour board certification course within a period of no more than two years prior to the date of application.

Board-approved providers and courses may be found at www.cebroker.com.

Have you successfully completed a board-approved 20-hour board certification course within the past two years?
Yes No

If you responded "Yes," provide proof of completion of the 20-hour course that includes the course name, course provider, number of hours awarded, and date of completion. Proof may be submitted by email to MQA.Opticianry@flhealth.gov, or by mail to:

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

Name: _____

5. DISCIPLINE HISTORY

Have you ever had any disciplinary action taken by the licensing authority of any state or are you the subject of any pending investigation or disciplinary action? Yes No

If you responded "Yes", 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" 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**.

Documentation must be mailed to:

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

6. APPLICANT SIGNATURE

I, the undersigned, confirm 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, ~~775.083 and 775.084,~~ 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.

~~S.~~ Section 456.013(1)(a), Florida~~.~~ Statutes~~.~~, provides that an incomplete application shall expire one year after the initial filing with the department.

I understand that I am under a continuing obligation to keep informed of any changes to ch. 456 and ~~&~~ 484, Part I, Florida~~.~~ Statutes~~.~~, and related rules and hereby state my license to practice opticianry in the state of Florida is not subject to any current disciplinary action.

Applicant Signature _____ Date _____
You may print this application and sign it or sign digitally. MM/DD/YYYY