



**APPLICATION INSTRUCTIONS
OPTOMETRY
PLEASE READ CAREFULLY**

APPLICANT'S QUESTIONS REGARDING APPLICATION AND SUPPORTING DOCUMENT STATUS: The Board office will notify you within 30 days after receiving your application and fee, informing you of any deficiencies in your application.

PLEASE NOTE: The Optometry Laws and Rules/Pharmacology examinations are now being administered by **computer based testing**. Once the applicant has been scheduled eligible, you will receive notification to schedule your actual test. **An additional fee will be required.** As a reminder to all applicants, please understand that Section 456.013(1)(a), Florida Statutes, indicates that an incomplete application shall expire one year after initial filing with the department.

APPLICATION DEADLINE: Pursuant to Rule 64B13-4.004(2), F.A.C., Applications for licensure must be received by the Department at least 120 days prior to the examination. Please visit www.flhealthsource.com for specific examination dates.

FEES:

OPTOMETRY LICENSURE EXAMINATION:

Application Fee:		\$ 250.00(NON-REFUNDABLE)
Initial Licensure Fee:		\$ 300.00
Unlicensed Activity Fee:		\$ 5.00
Department Administrative Costs*:	Clinical	\$ 1125.00
	Pharmacology	\$ 550.00
	Laws & Rules	\$ 100.00

TOTAL FEE: \$2,330.00

*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.

UPGRADE OPTOMETRIST TO CERTIFIED OPTOMETRIST - ONLY:

Application Fee:	\$ 250.00(NON-REFUNDABLE)
Duplicate License Fee:	\$ 25.00
Unlicensed Activity Fee:	\$ 5.00
TOTAL FEE:	\$ 280.00

All applications and fees should be mailed to: **(facsimile applications will not be accepted)**

(Please make certified check or money order payable to: DOH/Board of Optometry)

Department of Health
Florida Board of Optometry
Post Office Box 6330
Tallahassee, Florida 32314-6330

All supporting documents should be mailed to:

Department of Health
Florida Board of Optometry
4052 Bald Cypress Way, Bin #C07
Tallahassee, Florida 32399-3257
(850) 245-4355

OFFICIAL TRANSCRIPTS, NATIONAL BOARD SCORES AND LICENSURE VERIFICATIONS MUST BE MAILED DIRECTLY TO THIS BOARD OFFICE BY THE COLLEGE/UNIVERSITY, NATIONAL BOARDS AND STATE LICENSING AUTHORITIES.

SPECIAL APPLICANT: Defined as an applicant who responds “yes” on this application to any question, regarding a conviction, judgment or disposition to a misdemeanor or felony violation. **In submitting your application for this examination, you are required to list the date(s), circumstances surrounding the event(s), jurisdiction, offense, disposition, any certified documentation, your personal learning experience from the offense in letter format addressed to the Board of Optometry and any related information on a separate sheet of paper.**

MAILING ADDRESS: List the address where correspondence should be received. You can utilize a P.O. Box or practice mailing address in lieu of a home address if you want to avoid having your home address listed on the Web Site. Please take note of Chapter 119.07(2)(I)1., Florida Statutes, regarding exemptions from public disclosure.

PHOTO: One passport photos must accompany application.

PREVENTION OF MEDICAL ERRORS: A 2 hour course on the prevention of medical errors must be documented with the original certificate of attendance or a notarized copy, prior to licensure.

PLEASE NOTE: For the Prevention of Medical Errors courses, contact CE Broker by calling 1-877-434-6323 or at www.cebroke.com, to obtain.

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.

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.

EXAM ADMISSIONS: The BUREAU OF EXAMINATION SERVICES will provide admission slips and all necessary information approximately thirty days prior to the examination. If you do not receive this packet, contact (850) 245-4252.

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, Florida Administrative Code, 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 (Part I and Part II), with Practitioner Reporting & Examination Services, by the final published application deadline for the licensure examination for which the accommodation is requested. It is the responsibility of the candidate to provide adequate documentation of his/her disability.

For Optometry Candidates: The following eye conditions require special testing arrangements due to the testing format of the clinical examination and the optics of the Binocular Indirect Ophthalmoscope (BIO Headset) and the Biomicroscope.

1. Amblyopia
2. Strabismus
3. Any monocular vision impairment

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.

Special Testing Accommodations Due to Religious Conflicts: Modification to reporting times or alternate test dates may be requested by candidates who, due to their religious beliefs cannot attend the examination at the scheduled reporting time(s), or on the scheduled date(s). Candidates requesting such accommodation must make application with Practitioner Reporting & Examination Services, by the final published application deadline for the licensure examination for which the accommodation is requested. Each request should be accompanied by a letter from a religious leader specifying the religious restrictions that apply.

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

WEB SITE: You can also visit the board’s web site for additional information at www.doh.state.fl.us/mqa/optometry/index.html

WITHDRAWAL POLICY/REGULATION: If you are unable to take an examination for which you have applied, or if you wish to withdraw from an examination for which you have applied, **you must notify the Board Office in writing prior to being scheduled for the examination.**

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.



APPLICATION FOR OPTOMETRY EXAMINATION
(Client: 1801)

APPLICATION CATEGORY: (Please read instructions for important information and print or type application)

(CHECK APPROPRIATE CATEGORIES)

- INITIAL EXAMINATION Optometry Licensure Examination (all parts - required) ---(1010)
 RE-EXAMINATION --- Month/year of prior exam(s): _____ ---(1011)
 Clinical Practical Pharmacological Practical Laws & Rules
 Upgrade OPTOMETRIST to CERTIFIED OPTOMETRIST (Only)

PROFILE DATA:

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

- a. 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)

3. TELEPHONE: (____) _____ (____) _____
Home: Area Code/Phone Number Work: Area Code/Phone Number

4. PERSONAL DATA:

a. Date of Birth: _____ b. Place of Birth: _____
(Month/Day/Year)

c. E-mail Address: _____ d. What country are you a citizen of? _____

e. 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

FOR OFFICE USE ONLY-DO NOT WRITE BELOW THIS LINE

SCHOOL CODE: _____ EXAM SITE: _____ #OF RETAKES: _____

EDUCATION: _____ EXAM DATE: _____ ORIG. RECEIPT #: _____

DEGREE: _____ EXAM CODE: _____ CANDIDATE NO.: _____

Staple Photo (1)
DO NOT GLUE,
PASTE OR TAPE

PHARMACOLOGY PRACTICAL CLINICAL PRACTICAL LAWS & RULES

5. 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 five years?
 Yes No

6. APPLICANT HISTORY (ATTACH ADDITIONAL SHEETS IF NECESSARY)

Pursuant to Section 456.0635(2), Florida Statutes, the following questions are being asked. If you answer yes to any of the following questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation.

a. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396? YES NO (If no, do not answer b.)

b. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for each such conviction? YES NO

c. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?
 YES NO (If no, do not answer d.)

d. 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

e. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? YES NO (If no, do not answer f. and g.)

f. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years?
 YES NO

g. Did the termination occur at least 20 years prior to the date of this application? YES NO

h. 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

If YES, please list date, jurisdiction (state and county), offense, disposition, and all other related information on attached sheets. Certified copies of court disposition must be provided. (See special applicant in the application instructions)

i. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a 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 the purposes of this question. YES NO

If YES, please list date, jurisdiction (state and county), offense, disposition, and all other related information on attached sheets. Certified copies of court disposition must be provided. (See special applicant in the application instructions)

j. 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.

k. 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

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

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

n. 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

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

7. Have you served in the Armed Forces? [] YES [] NO
If yes, Entrance Date _____ Discharge Date _____ Honorable _____

8. 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 _____

9. 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	1976	[] Inter-American University	1985
[] University of Montreal	1983	(Puerto Rico)	

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

10. 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 SIGN HERE: _____ DATE: _____



PREVENTION OF MEDICAL ERRORS EDUCATION AFFIRMATION

TO: **FLORIDA BOARD OF OPTOMETRY**
4052 BALD CYPRESS WAY, Bin #C07
TALLAHASSEE, FLORIDA 32399-3257

FROM: _____
(Please print or type)

SS# _____

I hereby certify that I have completed an educational course on the prevention of medical errors as required by Florida Statutes. I understand that within the next two years I may be required to submit proof of my completion of this course if my license is selected for audit. Florida Law does not provide for an extension to complete this requirement.

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.

Signature (Required)

Date (of Signature)

Date of Examination you are applying for



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)