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

Florida Board of Optometry
4052 Bald Cypress Way, Bin C-07
Tallahassee, Florida 32399
850/245-4355

BOARD OF OPTOMETRY
INITIAL OPTOMETRY FACULTY
CERTIFICATE APPLICATION
(Client: 1805)

Fees: (1020)
Please complete form and return the fees (certified check or money order) to the address below. Also print legibly or type the information.

Application Fee	**$100.00**
Licensure Fee	**$100.00**
Unlicensed Activity Fee	**$ 5.00**
Total Fees:	**$205.00**

DATA PROFILE:
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:** _____

3. PERSONAL DATA:
BIRTH DATE: _____ **BIRTH PLACE:** _____
(Month/Day/Year) (City)(State/Province)(Country)

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

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NAME: _____

4. Are you a graduate of an accredited school/college of optometry approved by an accrediting agency recognized by the United States Office of Education? [ ] YES [ ] NO

5. Have you completed at least 110 hours of transcript quality coursework and clinical training in general and ocular pharmacology? If so, please select appropriate category:

Graduate of:

[ ] University of Alabama 1973
[ ] Southern College 1976
[ ] University of Missouri 1984
[ ] Southern California 1979
[ ] Northeastern State 1983
[ ] Ohio State 1972
[ ] University of Houston 1975
[ ] Illinois College 1976
[ ] Inter-American 1986
[ ] University of Montreal 1983
[ ] Indiana University 1976
[ ] University of Ca/Berkeley 1977
[ ] Newenco 1977
[ ] Ferris State College 1979
[ ] Pennsylvania College 1976
[ ] Waterloo Canada 1976
[ ] Pacific University 1977
[ ] SUNY 1975
[ ] Nova Southeastern 1993

Taken the following Course:

[ ] University of Houston 1966-74 90 hrs
[ ] Illinois College 1972-73 90 hrs
[ ] PCO 750 110 hrs
[ ] PCO 705 105 hrs
[ ] SUNY 1975
[ ] Waterloo Canada 1972-75 84 hrs
[ ] Illinois College 1974-75 102 hrs
[ ] PCO 750B 110 hrs
[ ] PCO 701 98 hrs
[ ] Illinois College 1986-87 98 hrs

APPLICANT HISTORY (ATTACH ADDITIONAL SHEETS IF NECESSARY)

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.

6. 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 7)** [ ] YES [ ] NO

a. If "yes" to 6, 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 6, 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 6, 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

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d. If "yes" to 6, 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

7. 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 7, 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

8. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? **(If "No", do not answer 8a.)** [ ] 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

9. 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 9a or 9b.)** [ ] 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

10. 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

11. If "yes" to any of the questions 6 through 10 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

LICENSURE INFORMATION:

12. LICENSURE INFORMATION: Do you hold or have you ever held a license to practice Optometry or any other profession in any U.S. State or territory, or foreign country? [ ] YES [ ] NO

_____	_____	_____	_____/_____/_____	_____/_____/_____
License Type	License Number	State/Country	Original Date Issued	Expiration Date
_____	_____	_____	_____/_____/_____	_____/_____/_____
License Type	License Number	State/Country	Original Date Issued	Expiration Date
_____	_____	_____	_____/_____/_____	_____/_____/_____
License Type	License Number	State/Country	Original Date Issued	Expiration Date

PLEASE NOTE: Verification of each license must be received directly from the licensing authority, regardless of status of license.

13. Have you committed any act or offense in any jurisdiction which would constitute the basis for discipline. **If yes, please explain and attach supporting documentation.** [ ] YES [ ] NO

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14. Please list the Florida based school/college where you have been offered and have accepted a full-time faculty appointment to teach in a program of optometry. **(Please submit a letter from the Dean confirming the appointment.)**

List the site(s) where you will be practicing:

_____

(School/College Name)

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.

_____ _____

Signature Date

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LICENSURE VERIFICATION FORM

I am applying for licensure in the State of Florida. The Florida Board of Optometry requires verification of licensure by each jurisdiction in which I hold or have ever held the section below and return directly to the Florida Board at the address listed below:

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.**

DH-MQA 1134, 7/2012
Rule 64B13-4.007, F.A.C.