



Board of Opticianry

Apprentice Optician Application

GENERAL INFORMATION

MAIL YOUR ORIGINAL APPLICATION AND FEE TO:

**Board of Opticianry
P. O. BOX 6330
Tallahassee, FL 32314-6330**

MAIL ALL CORRESPONDENCE AND SUPPLEMENTAL INFORMATION TO:

**Board of Opticianry
4052 Bald Cypress Way, Bin C08
Tallahassee, FL 32399-3258**

Within 30 days after receipt of an application, we will notify the applicant of any apparent errors or omissions and request any additional information required for the application to be considered complete. A complete application will be approved or denied within 90 days of completion.

SOCIAL SECURITY NUMBER: 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(12), 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 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 licensee identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L 193, Section 317.

LICENSEE INFORMATION ON THE INTERNET: When you become registered as an apprentice optician your name, license number and practice location address will be accessible through our Web site. The application asks for two addresses, a mailing address and a practice location address. All documents, including your license, will be sent to your mailing address. Your practice location address will be printed on your license and will show as your address of record on our Web site, which provides the public with information on licensed health care practitioners in the State of Florida. If you only provide one address, it will be used for both the mailing address and the practice location address.

ADDRESS CHANGE: If your address changes, you must provide written notification to the Board office. Include your full name, old address, new address, and whether this is your mailing address and/or your practice location address.

NAME CHANGE: If you have a legal name change, you must provide signed, written notification to the Board office. Include your full name as you applied, your new full name, and a photocopy of the applicable legal document. Your name cannot be changed without valid legal documentation.

DOCUMENTS IN A FOREIGN LANGUAGE: A certified translator who is not related to the applicant must translate any document that is in a language other than ENGLISH.

Please read the application instructions before completing the application and forms. We suggest you keep a copy of the completed application and all documents submitted for your records.

If you have further questions you may contact the Board office at (850) 245-4444 ext. *3457 between the hours of 8:00 AM and 5:00 PM EST.

Please visit our Web site at www.doh.state.fl.us/mqa/opticianry

All licensees are responsible for knowing the laws and rules that regulate their profession. The laws in Chapter 484, Part I, Florida Statutes, are directly related to the profession of Opticianry, and Chapter 456, Florida Statutes, governs all health care professions licensed by the Department of Health. Rule Chapter 64B12, Florida Administrative Code, are the rules that govern the profession of Opticianry. Rule Chapter 64B29, Florida Administrative Code, are the rules for optical establishments. The laws and rules are accessible at the Opticianry Web site listed above.

Apprentice Application Instructions

The Board office will notify you within thirty days after we receive your application and fee, informing you of any deficiencies in your application. A complete application consists of a completed application form and ALL required supporting documentation. Pursuant to section 456.013(1)(a), Florida Statutes, an incomplete application shall expire one year after initial filing with the department.

REQUIRED FEE

Submit a check or money order in the amount of \$60.00 payable to the Department of Health. This registration fee is non-refundable and must be submitted with your application.

COMPLETING THE FORMS

Original forms must be submitted; photocopies of signatures will not be accepted. Complete all forms by printing neatly in black ballpoint pen or typing all information.

FILLING OUT THE APPRENTICE OPTICIAN APPLICATION

Questions must be answered fully and truthfully. Obtaining a license by fraudulent misrepresentation is grounds for denial of your application or revocation of your license. It is your responsibility to notify this office in writing if the answers to any of these questions change.

1. **Applicant Profile Data.** List your full legal name as it should appear on your license. Attach one passport style photograph to the lower right corner of the application. Please print your first and last name on the back of the photograph.
2. **Education.** Provide a photocopy of your high school diploma, transcript or equivalency certificate. If you attended a school of opticianry and want credit toward your apprenticeship hours, you must request an official transcript be sent directly to the Board office. A transcript will not be considered official if received from the applicant. Each credit hour earned at such school shall count as 86.67 apprenticeship hours. See rule 64B12-16.003(4), Florida Administrative Code (F.A.C.)
3. **Sponsor Information.** Provide the name, address, and license number of the individual who has agreed to be your primary sponsor. If you have a secondary sponsor, provide their name, address, and license number. A completed Sponsor Registration Form must be included with your application. Please note that all apprentices must complete training in filling, fitting, and adapting contact lenses. Failure of your sponsor(s) to either mark “yes” that you will receive contact lens training or “no” that you will not receive contact lens training will delay the processing of your application. Your primary sponsor must sign this form and if you have a secondary sponsor, he or she must also sign the form.

- Approved sponsors include opticians licensed in Florida for at least one year, Florida-licensed optometrists, Florida-licensed allopathic physicians, and Florida-licensed osteopathic physicians with a clear, active license. An approved sponsor may only sponsor a total of two apprentices at one time and an apprentice may have no more than two sponsors at one time.
- A licensed optician that is not board certified may not train an apprentice in filling contact lens prescriptions and fitting and adapting contact lenses. Training in contact lenses must be provided by a Florida board-certified optician, a Florida-licensed optometrist, a Florida-licensed allopathic physician, or a Florida-licensed osteopathic physician. See Rule 64B12-16.003(6)(h), F.A.C.
- If your sponsor does not qualify to train you in contact lenses, you must find a sponsor who is qualified to train you or complete a Board approved course equivalent to 32 hours as a substitute for working experience with contact lenses.

4. **Applicant History-Professional.** If you answer “yes” to any question(s) in this section you must provide the Board complete details.

5. **Applicant History-General.** Read these questions carefully. If you answer “yes” to any question in this section you must provide the Board complete details. You may be asked to submit a current mental health status report from a licensed mental health professional.

Keep in mind, a "yes" answer does not mean the application will automatically be denied, but failure to provide the correct information may result in licensure denial. The Board carefully reviews each applicant's history to determine that the applicant is able to practice the profession with reasonable skill and competence.

6. **Applicant History** – Pursuant to Section 456.0635, Florida Statutes.
These questions are asked pursuant to Section 456.0635(2), Florida Statutes.

7. **Applicant Statement.** Read this section carefully. Your signature is required.

PLEASE NOTE: There is no provision in Chapter 484, Part I, Florida Statutes, or Rule Chapter 64B12, F.A.C., to allow credit for any time worked prior to registration in the apprenticeship program.



Apprentice Optician Application (2002)

1. APPLICANT PROFILE DATA (PLEASE TYPE OR PRINT IN BLACK INK)

Name	Last	First	Middle
Mailing Address	No. and Street .		Apt. No.
	City	State	Zip Code
* Practice Location Address	No. and Street		Apt. No.
	City	State	Zip Code

DO NOT WRITE IN THIS SPACE FOR OFFICE USE ONLY

Date of Birth: _____/_____/_____

Place of Birth: (City, State)

Have you ever changed your name through marriage or through action of a court, or have you ever been known by any other name?
 YES NO If "YES", list name(s) and date(s) of changes:

Home Telephone: Area Code ()	Business Telephone: Area Code ()	Fax Number: Area Code ()
E-Mail Address: (optional)		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female

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 38295 (8/25/78). This information is gathered for statistical purposes only and does not in any way affect your candidacy for licensure.

RACE: Caucasian African-American Hispanic Asian Native American Other _____

2. EDUCATION

Name & Address of High School _____

Received: Diploma GED Date Completed: _____

Name & Address of Optical School (if any) _____

3. SPONSOR INFORMATION

Primary Sponsor's Name: _____ Primary Sponsor's License No.: _____

Optician Board Certified Optician Optometrist Allopathic Physician Osteopathic Physician

Secondary Sponsor's Name: _____ Secondary Sponsor's License No.: _____

Optician Board Certified Optician Optometrist Allopathic Physician Osteopathic Physician

* Your Practice Location Address will show on the Internet License Verification screen, which provides the public with information on licensed health care practitioners in the State of Florida. If you only provide one address, it will be used for both the mailing address and the practice location address.

A Post Office box is not acceptable for the practice location address.

Tape one 2" x 2" photo here taken within the last six months.
 Photo must be professional quality showing only the head and shoulders.

Print name on back of photo

4. APPLICANT HISTORY – PROFESSIONAL	
A. Have you ever been denied licensure for Opticianry or any health-related profession or the renewal thereof in any state?	<input type="checkbox"/> YES <input type="checkbox"/> NO
B. Have you ever been denied the right to take an Opticianry licensure examination?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
D. Are you now or have you ever been a defendant in civil litigation in which the basis of the complaint against you was alleged negligence, malpractice or lack of professional competence?	<input type="checkbox"/> YES <input type="checkbox"/> NO
E. Is there currently pending, in any jurisdiction, a complaint or investigation against your professional conduct or competency?	<input type="checkbox"/> YES <input type="checkbox"/> NO
F. Have you ever been involved in, reprimanded for or disciplined by an employer or educational institution for misconduct including:	
1. Acts of dishonesty, fraud, or deceit	1. <input type="checkbox"/> YES <input type="checkbox"/> NO
2. Lying on a resume or misrepresentation	2. <input type="checkbox"/> YES <input type="checkbox"/> NO
3. Academic misconduct, including acts such as cheating or plagiarism	3. <input type="checkbox"/> YES <input type="checkbox"/> NO
4. Theft	4. <input type="checkbox"/> YES <input type="checkbox"/> NO
5. Sexual harassment	5. <input type="checkbox"/> YES <input type="checkbox"/> NO
If you answered "YES" to any question in Section 4, you must provide the Board complete details.	
5. APPLICANT HISTORY – GENERAL	
A. Have you ever been convicted of, or entered a plea of guilty or nolo contendere (no contest) to any 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 purposes of this question. If you answer YES, you must explain in detail on a separate sheet. In your explanation, include dates, jurisdictions, offenses, specific circumstances, and dispositions. You must include a certified copy of the court records/dispositions.	<input type="checkbox"/> YES <input type="checkbox"/> NO
B. In the last 5 years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past 5 years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
C. In the last 5 years, have you been admitted to or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	<input type="checkbox"/> YES <input type="checkbox"/> NO
D. During the last 5 years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice as an Optician within the past 5 years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
E. During the last 5 years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice as an Optician?	<input type="checkbox"/> YES <input type="checkbox"/> NO
F. In the last 5 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 5 years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
G. During the last 5 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 as an Optician within the past 5 years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If you answered "YES" to any question in Section 5, you must provide the Board complete details. A "YES" answer does not mean the application will be denied; however, failure to provide the correct information may result in registration denial.	

6. 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.

- | | | |
|-----|--|--|
| 1a. | 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? (If no, do not answer 1b.) | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 1b. | 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 such conviction? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2a. | Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If no, do not answer 2b.) | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2b. | If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3a. | 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? (If no, do not answer 3b and 3c.) | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3b. | Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3c. | Did the termination occur at least 20 years prior to the date of this application? | <input type="checkbox"/> YES <input type="checkbox"/> NO |

7. APPLICANT STATEMENT

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past or present), business and professional associates (past or present), and all government agencies and instrumentalities (local, state, federal, or foreign) to release to the Department of Health any information, files, or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organizations, 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 s. 456.072, F.S., and 456.013(1)(a), F.S. Failure to do so may result in disciplinary action by the Board including denial of licensure.

I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind. I declare that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to s. 456.067, F.S., or criminal penalties pursuant to s. 775.082, s. 775.083, or s. 775.085, F.S. Should I furnish any false information on this application, I hereby acknowledge that such act may constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida.

I hereby state that my sponsor and I have reviewed, together, Chapter 484, Part I, F.S., and Chapter 64B12, F.A.C., and specifically 64B12-16. I fully understand my responsibilities to my sponsor, the Board of Opticianry and the Department of Health, and the limitations of being registered in the apprenticeship program herein designated. I understand that it is my responsibility to keep informed of any changes to Chapter 484, Part I, F.S., and 64B12, F.A.C.

I understand that pursuant to s. 456.013(1)(a), F.S., an incomplete application shall expire 1 year after initial filing.

I understand that pursuant to Rule 64B12-16.003(4)(a), F.A.C., I am required to complete a two-hour Apprentice/Sponsor Orientation Course within one year of registration in the apprenticeship program. I have also informed my sponsor(s) that if they attend a two-hour Apprenticeship/Sponsor Orientation Course, it will count toward the laws and rules continuing education requirement for renewal of their optician license.

 Applicant's Signature

 Date

BOARD OF OPTICIANRY

SPONSOR REGISTRATION FORM

Print clearly in black ballpoint pen or type all information.

APPRENTICE INFORMATION

Apprentice Full Name: _____

Number of hours this apprentice will work per week under direct supervision of a sponsor: _____

PRIMARY SPONSOR GENERAL INFORMATION (Signature required below)

Sponsor Name _____ Business Name _____

Address/City/State/Zip _____

Telephone Number: () _____ FAX () _____

Primary Sponsor's License Number _____ Profession _____

Rule 64B12-16.003, F.A.C., requires the apprentice to complete training in filling, fitting and adapting contact lenses as a part of the apprenticeship training. Will this training be provided by the primary sponsor?

Yes No [One of these boxes must be checked.]

SECONDARY SPONSOR GENERAL INFORMATION (if applicable)

Secondary Sponsor Name _____ Business Name _____

Address/City/State/Zip _____

Telephone Number () _____ FAX () _____

Secondary Sponsor's License Number _____ Profession _____

Rule 64B12-16.003, F.A.C., requires the apprentice to complete training in filling, fitting and adapting contact lenses as a part of the apprenticeship training. Will this training be provided by the secondary sponsor?

Yes No [If this section is completed, one of these boxes must be checked.]

I state that I do dispense eyewear and maintain all of the equipment required by Rule 64B12-10.007, F.A.C., on the same premises where the apprentice works. I further state that my apprentice and I have reviewed, **together**, Chapter 484, Part I, Florida Statutes, and Rule Chapter 64B12-16, Florida Administrative Code. I declare that I fully understand my responsibilities to my apprentice and to the Board of Opticianry and the Department of Health, as a properly registered sponsor of an apprentice registered in the Opticianry apprenticeship program.

Signature of Primary Sponsor

Signature of Secondary Sponsor (if applicable)