Optician Apprentice Application for Registration



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

Website: www.floridasopticianry.gov Email: MQA.Opticianry@flhealth.gov

Phone: (850) 245-4292

Fax: (850) 413-6982







Are you an active-duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered "Yes" to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health's commitment to serving members and veterans of the United States Armed Forces and their families online at

http://www.flhealthsource.gov/valor





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Do Not Write in this Space For Revenue Receipting Only

There is no provision in chapter (ch.) 484, Part I, Florida Statutes, or Rule ch. 64B12, Florida Administrative Code (F.A.C.), to allow credit for any time worked prior to registration in the apprentice program.

Apprentice Optician (2002) \$60.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. The application fee is non-refundable.

Name:						Date of Birth:	:
L	.ast/Surname	;	First		Middle		MM/DD/YYYY
Mailing A	ddress: (The	e address wh	here mail and your	license should b	e sent)		
Street/P.C). Box				Apt. No.	City	
State			ZIP	Country		Home/Cell Telephone	
Practice L	_ocation: (R	equired if ma	ailing address is a f	P.O. Box- This a	ddress will b	e posted on the Department o	of Health's website
Street	(Plac	e of Employı	ment)		Suite No.	City	
State	 		ZIP	Country		Work/Cell Telephone	
State EQUAL O	PPORTUNIT	ΓΥ DATA:	ZIP	Country		Work/Cell Telephone	
EQUAL O We are red Uniform G	quired to ask uidelines on	that you fur Employee S	nish the following in Selection Procedure	nformation as pa e (1978); 43 FR 3	88295 and 38	Work/Cell Telephone luntary compliance with 41 Cl 3296 (August 25, 1978). This your candidacy for licensure.	information is
EQUAL O We are red Uniform G	quired to ask uidelines on	that you fur Employee S	nish the following in Selection Procedure g purposes only an Native Hawaiiar	nformation as pa e (1978); 43 FR 3 id does not in an n or Pacific Island n or Alaska Nativ	88295 and 38 y way affect der H	luntary compliance with 41 Cl 3296 (August 25, 1978). This	information is
EQUAL O We are red Uniform G gathered f Gender: nail Notifi e provided	quired to ask uidelines on for statistical Male Female	that you fur Employee S and reportin Race: e notified of se to be noti	nish the following in Selection Procedure g purposes only an Native Hawaiiar American Indian Two or More Ra	nformation as pa e (1978); 43 FR 3 id does not in an n or Pacific Island n or Alaska Nativ aces	8295 and 38 y way affect der	luntary compliance with 41 Cl 3296 (August 25, 1978). This your candidacy for licensure. Hispanic or Latino	information is White Asian nail address on the

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:		
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.

3.	APPLICANT BACKGROUND
	List any other name(s) by which you have been known in the past. Attach additional sheets if necessary.
4.	EDUCATION HISTORY
	List high school/college/university education, whether completed or not, in chronological order.

Name:

School Name	City/State or Country	Graduation Date (MM/DD/YYYY)	Degree Awarded

Provide a photocopy of your high school diploma, transcript or equivalency certificate. If you attended a postsecondary school and want credit toward your apprenticeship hours, each credit hour earned at such school shall count as 86.67 apprenticeship hours. See Rule 64B12-16.003(4), F.A.C. A transcript will not be considered official if received from the applicant. Transcript must be sent in the official sealed envelope directly from the university. Send via electronic secure transfer to MQA.Opticianry@flhealth.gov or by mail to:

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

Documents in a foreign language must be translated in English by a certified translator, who is not related to the applicant.

5. SPONSOR INFORMATION

- 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.

Primary				
Sponsor Name:			_ Primary Sponsor Licens	e #:
Optician	Board Certified Optician	Optometrist	Allopathic Physician	Osteopathic Physician
Secondary			,,	
Sponsor Name:			_ Secondary Sponsor Lice	ense #:
Optician	Board Certified Optician	Optometrist	Allopathic Physician	Osteopathic Physician

Name:	

This information is exempt from public records disclosure.

6. 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 substancerelated (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:	

7. 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 had any professional license or license to practice revoked, suspended, or any other disciplinary action taken in any state or other jurisdiction? Yes No
- C. Have you ever been denied the right to take an opticianry examination? Yes No
- D. Is there a complaint or investigation against your professional conduct or competency currently pending in any jurisdiction? 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?	
				Υ	Ν
				Y	N
				Y	N
				Υ	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**.

8. CRIMINAL HISTORY

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? 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. Yes No

If you responded "Yes" in this section complete the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?	
				Υ	Ζ
				Υ	N
				Υ	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.

be	excl	RTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may luded from licensure, certification, or registration if their felony convictions fall into certain timeframes as shed in s. 456.0635(2), Florida Statutes.				
1.	I. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under ch. 409, Florida Statutes (relating to social and economic assistance), ch. 817, Florida Statute (relating to fraudulent practices), ch. 893, Florida Statutes (relating to drug abuse prevention and control), similar felony offense(s) in another state or jurisdiction? Yes No If you responded "No" to the question above, skip to question 2.					
	ıı y	rou responded 140 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.	felo	ve you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a ony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare d Medicaid issues)? Yes No				
	lf y	ou 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.		ve you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, Florida atutes? Yes No				
	If y	ou 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.		ve you ever been terminated for cause, pursuant to the appeals procedures established by the state, from y other state Medicaid program? Yes No				
	lf y	ou 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				

Name: _____

9. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

 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)?
 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 a 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 self-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.
Documents in sections 6, 7, 8, and 9 must be mailed to the board office at:
Board of Opticianry
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3257
10. 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.
I hereby state that my sponsor and I have reviewed, together, ch. 484, Part I, Florida Statutes, and ch. 64B12, F.A.C and specifically Rule ch. 64B12-16, F.A.C. 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 ch. 484, Part I, Florida Statutes, and Rule 64B12, F.A.C.
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, the course will count toward either the elective or the laws and rules continuing education requirement for the renewal of their optician license.
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 the application and sign it or sign digitally.

Name: __

MM/DD/YYYY

This form is required for all applicants. Complete registration forms must be mailed directly from the sponsor to:

Board *of* **Opticianry** 4052 Bald Cypress Way Bin C-08 Tallahassee, FL 32399-3258

Apprentice Information



Board of Opticianry Sponsor Registration Form

Page 1 of 2

- 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
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- 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.

Apprentice Full Name:		
Number of hours this apprentice will work	per week under direct supervision of a sponsor:	
Primary Sponsor General Informat	<u>on</u>	
Sponsor Name	Business Name	
Address/City/State/ZIP		
Telephone Number	Fax	
Primary Sponsor License #	Profession	
•	pprentice to complete training in filling, fitting and adapting contact lenses becensed optometrist, a Florida licensed allopathic physician, or a Florida lice provided by the primary sponsor?	•
Yes No (You must check on	.)	
Secondary Sponsor General Inform	ation (if applicable)	
Secondary Sponsor Name	Business Name	
Address/City/State/ZIP		
Telephone Number	Fax	
Secondary Sponsor License #	Profession	
•	apprentice to complete training in filling, fitting and adapting contact lenses becensed optometrist, a Florida licensed allopathic physician, or a Florida lice provided by the secondary sponsor?	•

Yes No (If this section is completed, you must check one.)

Board of Opticianry Sponsor Registration Form

Page 2 of 2



Apprentice Full Name:	
premises where the apprentice works. I further state tha Florida Statutes, and Rule 64B12-16, F.A.C. I declare th	uipment required by Rule 64B12-10.007, F.A.C., on the same my apprentice and I have reviewed, together , ch. 484, Part I, at I fully understand my responsibilities to my apprentice and to a properly registered sponsor of an apprentice registered in the
Primary Sponsor Signature	Date (MM/DD/YYYY)
Secondary Sponsor Signature (if applicable)	Date (MM/DD/YYYY)