



# Board of Opticianry

## Re-Examination Application

Department of Health  
Florida Board of Opticianry  
4052 Bald Cypress Way, #C-08  
Tallahassee, FL 32399-3258  
Telephone: (850) 245-4474  
[www.floridasopticianry.gov](http://www.floridasopticianry.gov)  
Email: [MQA.Opticianry@flhealth.gov](mailto:MQA.Opticianry@flhealth.gov)

# Opticianry Re-Examination Application Instructions

## Requirements for Re-Examination

- Completion of the Opticianry Re-Examination Application;
- Payment of \$100.00 application fee, which is non-refundable; **and**
- Date of original failed examination is within two years of submitting the re-examination application.

The fee must accompany the application. Please make the check or money order payable to the Department of Health. Mail the application and fee to:

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

**Exam Review Course:** The Board of Opticianry does **not** offer an examination review course. Furthermore, there are **no** examination review courses that are endorsed by the Board of Opticianry.

**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 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.

## Requirements For Licensure As An Optician

- Successful completion of all parts of the examination for Florida licensure;
- The original certificate documenting successful completion of a two-hour laws and rules course by a Board approved laws and rules course provider;
- Copy of certificate documenting successful completion of a two-hour continuing education course relating to the prevention of medical errors. The course must be approved by the Board and shall include a study of root-cause analysis, error reduction and prevention, and patient safety;
- Copy of certificate documenting successful completion of a two-hour live technical practice continuing education course on fitting and adjusting by a Board approved provider;
- No discovery of disqualifying factors prior to licensure;
- Payment of the initial licensure fee within one (1) year of notification of successful passage of the examination for Florida licensure; **and**
- Completion of Initial Licensure Form, see last page of this application packet.

All licensees are responsible for knowing the laws and rules that regulate their profession. The laws in Chapter 484, Part I, Florida Statutes (F.S.), are directly related to the profession of Opticianry, and Chapter 456, F.S., governs all health care professions licensed by the Department of Health. The rules in 64B12, Florida Administrative Code (F.A.C.), govern the profession of Opticianry. The rules in 64B29, F.A.C., govern optical establishments. The laws and rules are accessible at the Opticianry Website at [www.floridasopticianry.gov](http://www.floridasopticianry.gov).

## COMPLETING THE APPLICATION

Original forms with an original signature must be submitted; photocopies will not be accepted. Print neatly in black ballpoint pen or type all information.

**Section I. Applicant Profile Data:** List your full legal name as it should appear on your license.

**Section II. Examination History:** List the date of your original examination and the dates of any retake examinations.

**Section III. Examination Portion(s) You Are Applying To Re-Take:** If you need to re-take only one portion of the examination, check the appropriate box on the form. If you need to re-take both the spectacle and the contact lens portions of the examination, check both boxes on the form.

**Section IV. Applicant History-Professional:** If you answer “yes” to any question(s) in this section you must provide the board complete details. If you have already provided the board with complete details, submit a letter stating that you have already provided complete details and there have been no additional issues since you submitted your previous application.

**Section V. Applicant History-General:** If you answer “yes” to the history question in this section, 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 dispositions. If you have already provided the board an explanation and required copies, submit a letter stating that you already submitted an explanation and copies, and there have been no additional issues since you submitted your previous application.

**Section VI. Applicant History – Pursuant to Section 456.0635, Florida Statutes:**

**IMPORTANT NOTICE:** Effective July 1, 2012, section 456.0635, Florida Statutes, provides that health care boards or the department **shall refuse** to issue a license, certificate or registration and **shall refuse** to admit a candidate for examination if the applicant:

1. Has been convicted of, or entered a plea of guilty or nolo contendere to, 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 unless the candidate or applicant has successfully completed a drug court program for that felony and provides proof that the plea has been withdrawn or the charges have been dismissed. Any such conviction or plea shall exclude the applicant or candidate from licensure, examination, certification, or registration, unless the sentence and any subsequent period of probation for such conviction or plea ended:
  - For the felonies of the first or second degree, more than 15 years from the date of the plea, sentence and completion of any subsequent probation;
  - For the felonies of the third degree, more than 10 years from the date of the plea, sentence and completion of any subsequent probation;
  - For the felonies of the third degree under section 893.13(6)(a), F.S., more than five years from the date of the plea, sentence and completion of any subsequent probation;
2. Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, 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), unless the sentence and any subsequent period of probation for such conviction or pleas ended more than 15 years prior to the date of the application;
3. Has been terminated for cause from the Florida Medicaid program pursuant to section 409.913, F.S., unless the candidate or applicant has been in good standing with the Florida Medicaid program for the most recent five years;

4. Has been terminated for cause, pursuant to the appeals procedures established by the state or Federal Government, from any other state Medicaid program, unless the candidate or applicant has been in good standing with a state Medicaid program for the most recent five years and the termination occurred at least 20 years before the date of the application;
5. Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

**NOTE:** This section **does not apply** to candidates or applicants for initial licensure or certification who were enrolled in an educational or training program on or before July 1, 2009, which was recognized by a board or, if there is no board, recognized by the department, and who applied for licensure after July 1, 2012.

**Section VII. Applicant Statement:** Read this entire section then sign and date. Your original signature is required.

**Section VIII. Social Security Number:** Your Social Security number is required.

**Section IX. Applicant History – Health:** The Board reviews each applicant's history to determine that the applicant is able to practice the profession with reasonable skill and competence. If you have a history of serious, chronic, or recent mental health problems or addiction to drugs, you must submit a current mental health status report. Mental health status reports must come from a licensed mental health professional, with which you have no personal or professional relationship, wherein this professional opines that you are able to practice with reasonable skill and safety to patients or clients.

**Florida Department  
of Health**

**Opticianry  
Re-Examination  
Application (2001)**

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

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

Home Telephone:  
Area Code ( )

Business Telephone:  
Area Code ( )

Fax Number:  
Area Code ( )

E-Mail Address:

Sex:  Male  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 \_\_\_\_\_

**II. EXAMINATION HISTORY**

List the date(s) of previous examination(s): Original Examination Date \_\_\_\_\_

Retake Date \_\_\_\_\_ Retake Date \_\_\_\_\_ Retake Date: \_\_\_\_\_

**III. EXAMINATION PORTION(S) YOU ARE APPLYING TO RE-TAKE**

Spectacle Portion  Contact Lens Portion

Your Practice Location Address will show on our Internet License Verification, 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.

The practice location address must be a street address.

#### IV. APPLICANT HISTORY – PROFESSIONAL

- 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 been denied the right to take an Opticianry licensure examination?  YES  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?  YES  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?  YES  NO
- E. Is there currently pending, in any jurisdiction, a complaint or investigation against your professional conduct or competency?  YES  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 6, you must provide the board complete details.

#### V. APPLICANT HISTORY – GENERAL

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.  YES  NO

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.

**VI. APPLICANT HISTORY - Pursuant to Section 456.0635(2), Florida Statutes,**

**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. Supporting documentation includes court dispositions or agency orders where applicable.

- |  |  |
|--|--|
| 1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, 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?<br>(If you responded "no", skip to # 2.) | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 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?   | <input type="checkbox"/> YES <input type="checkbox"/> 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 any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| c. If "yes" to 1, for the 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?   | <input type="checkbox"/> YES <input type="checkbox"/> 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", please provide supporting documentation).   | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, 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)?  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 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?   | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?<br>(If "No", do not answer 3a.)  | <input type="checkbox"/> YES <input type="checkbox"/> 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?  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?<br>(If "No", do not answer 4a or 4b.)  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| a. Have you been in good standing with a state Medicaid program for the most recent five years?  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| b. Did the termination occur at least 20 years before the date of this application?  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 5. 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?  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 6. If "yes" to any of the questions 1 through 5 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.)   | <input type="checkbox"/> YES <input type="checkbox"/> NO |

## VII. 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.

The practice of Opticianry in Florida is governed by Chapters 456 and 484, Part I, Florida Statutes, and Chapter 64B12, Florida Administrative Code, which I state I have read and understand. I understand that it is my responsibility to keep informed of any changes to Chapters 456 and 484, Part I, F.S., and Chapter 64B12, Florida Administrative Code.

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

I further state that I will comply with all requirements for licensure renewal, including continuing education credits.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date







# INITIAL LICENSURE FORM OPTICIANRY (2001)

Do not write in this space.

**Please Note:** According to Rule 64B12-9.0015(5), Florida Administrative Code, the initial licensure fee **must** be paid within one year of notification of successful passage of the examination.

To receive your initial license, please complete and return this form with a check or money order made payable to the Department of Health for the initial licensure fee. The licensure biennium ends on December 31 of every even-numbered year. Please determine the correct amount of your initial licensure fee from the following information:

- If you submit the fee in an odd-numbered year, the initial licensure fee is \$130.00 and you will be required to renew your license by December 31 of the following year. (Example: Submit \$130 on 11/10/2013 and your first renewal will be 12/31/2014.)
- If you submit the fee between January 1 and August 30 of an even-numbered year, the initial licensure fee is \$67.50 and you will be required to renew your license by December 31 of the same year. (Example: Submit \$67.50 on 8/15/2014 and your first renewal will be 12/31/2014.)
- If you submit the fee after August 30 of an even-numbered year, the initial licensure fee is \$130.00 and you will be required to renew your license by December 31 of the next even-numbered year. (Example: Submit \$130 on 9/5/2014 and your first renewal will be 12/31/2016.)

Note: The renewal cycle begins on September 1 of each even-numbered year and when a license is issued during the renewal cycle, the expiration date is for the following biennium.

NAME (PRINT NEATLY OR TYPE ALL INFORMATION) \_\_\_\_\_

LAST FOUR DIGITS OF YOUR SOCIAL SECURITY NUMBER \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

LOCATION ADDRESS \_\_\_\_\_

CHECK THIS BOX IF YOUR MAILING OR LOCATION ADDRESS HAS CHANGED

Please return this form with a check or money order to:

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