



Board of Opticianry

Application for
Licensure Examination

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.

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.

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 licensed 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.

LICENSE/CERTIFICATE/REGISTRATION VERIFICATION: This form is required **only if** you hold or have ever held a license, certificate, or registration in any state or U.S. territory. You must mail this form to each agency that issued you a license, certificate, or registration. That agency must complete the form and mail the form directly to the Board office. It will not be considered official if the verification form is received from the applicant.

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.

Opticianry Examination Application Instructions

The Board office will notify you within thirty days after we receive your application and fees, 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.

To be certified eligible to take the Florida Opticianry Licensure Examination you must successfully pass the American Board of Opticianry Examination (ABO) and the National Contact Lens Examination (NCLE) through the American Board of Opticianry and National Contact Lens Examination, 10341 Democracy Lane, Fairfax, VA 22030, 1-800-296-1379. You will be required to submit proof of either current certification in the ABO and NCLE or proof of passing each exam **within three years of application.**

The Florida Opticianry Licensure Examination consists of the following three parts:

- The **neutralization examination** requires candidates to neutralize lenses within the tolerances set out in the American National Standard (Z80.1-1987). A score of at least 70% is required to pass this examination.
- The **dispensing problems examination** is taken via computer at a testing center. A score of at least 70% is required to pass this examination.
- The **practical examination** consists of (1) measuring and calipering, (2) lens identification, (3) fitting and adjusting, and (4) pupillary distance. A score of at least 70% is required to pass this examination.

INITIAL LICENSURE CONSISTS OF THE FOLLOWING REQUIREMENTS:

- Passing score on the Florida Opticianry Licensure Examination
- The original certificate documenting successful completion of a two-hour initial licensure laws and rules course from a Board approved laws and rules course provider
- Copy of certificate documenting completion of a two-hour continuing education course relating to the prevention of medical errors
- Payment of the initial licensure fee within one (1) year of notification of successful passage of the examination

REQUIRED FEES

Submit a check or money order in the amount **\$670.00** made out to the Department of Health. This includes an application fee of \$100.00 plus the examination fee of \$570.00. Your fees must be submitted with your application. **The application fee is non-refundable.** In addition, you will be required to pay a fee for the dispensing problems examination to the testing site at the time you schedule this exam.

EXAM ADMISSIONS

Testing Services will provide admission slips and all necessary information approximately 30 days prior to the examination date. If you do not receive this packet, please call testing at (850) 245-4252.

SPECIAL TESTING ACCOMMODATIONS

Candidates requesting special testing accommodations due to disability must file a completed application for special testing accommodations at least 60 days prior to the examination date. Applicants who have previously received special testing accommodations for an examination and need an accommodation for another examination or a retake of the same examination must file a reapplication with Testing Services, Bureau of Operations each time accommodation is needed.

Modification to reporting times or alternate test dates may be requested by candidates who, due to religious conflicts, cannot attend the examination at the scheduled reporting time(s) or on the scheduled date(s). Candidates requesting such accommodation must file a completed application for special testing accommodations due to religious conflict at least 60 days prior to the examination date.

You can download the special testing accommodation application and instructions at <http://www.doh.state.fl.us/mqa/Exam/spectest.htm>. If you do not have the ability to download the application forms, please contact Testing Services, Bureau of Operations at 850-245-4252 to request an application for special testing accommodations well in advance of the deadline.

APPLICATION DEADLINES

The postmark deadline for your application and fees is ninety (90) days prior to the examination date. Your completed application, including all supporting documentation, with appropriate fees must be received in the Board office at least sixty (60) days before the examination. The dates of the scheduled examinations may be found at <http://www.doh.state.fl.us/mqa/Exam/schedule-do.htm#opticianry>.

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 OPTICIANRY EXAMINATION APPLICATION

Pages 1 and 2 are identical, you must either complete both pages or you may complete one page and make a Xerox copy for the next page. Both pages must be submitted with a photo taped to each page. 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 both page 1 and page 2 of the application. Please print your first and last name on the back of each photograph. Your practice location address will show on our Internet license lookup screen.

2. **Education:** Provide a photocopy of your high school diploma or equivalency certificate.
3. **Eligibility Data:** Indicate your method of application and provide the appropriate documentation.
 - **Apprenticeship** – Please provide your apprentice (DA) number or a copy of your apprenticeship completion letter.
 - **Associate Degree in Opticianry** – You must request that an official transcript be sent from the accredited institution where you received your Associate’s degree directly to the Board office or it will not be considered official. The transcript must show that the degree was awarded.
 - **Licensed and has Actively Practiced in Another State, Territory, or Jurisdiction of the United States for Three (3) of the Last Five (5) Years** – The License/Certificate/Registration Verification form must be completed by the state(s) in which you **hold or** have ever held a license, certificate, or registration. This form must be completed and sent directly to us from the agency which issued the license, certificate, or registration, or it will not be considered official. OR
 - **Actively Practiced in Another State, Territory, or Jurisdiction of the United States for Five (5) of the Last Seven (7) Years** – If you practiced in a state that does not require a license please provide tax records, business records, affidavits, or other satisfactory documentation showing proof of practice of Opticianry.

Two current 2” x 2” passport-style photographs are required and they must be facial photos of you only. Copies of photos and photos of more than one person will not be accepted. Please print your first and last name on the back of the photographs and tape one to the lower right corner of the first page of the application and one to the lower right corner of the second page of the application.

4. **Applicant Licensure Status.** A License/Certificate/Registration Verification form is required from each state or U.S. territory where you hold or have ever held a license, certificate, or registration to practice Opticianry.
5. **Professional Experience.** Starting with the most recent, list all Opticianry work experience. Do not leave any blanks or lapses in time. If you were unemployed or not working in an optical setting, these should also be listed.
6. **Applicant History-Professional.** If you answer “yes” to any question(s) in this section you must provide the Board complete details.
7. **Applicant History-General.** Read these questions very carefully. If you answer “yes” to any question(s) 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.

8. **Applicant History** – Pursuant to Section 456.0635, Florida Statutes.
These questions are asked pursuant to Section 456.0635(2), Florida Statutes.
9. **Applicant Statement.** Read this entire section. Your original signature is required.



Opticianry Application For Licensure Examination (2001)

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

Name	Last	First	Middle	DO NOT WRITE IN THIS SPACE FOR OFFICE USE ONLY
Mailing Address	No. and Street .		Apt. No.	
	City	State	Zip Code	
* Practice Location Address	No. and Street		Apt. No.	
	City	State	Zip Code	
			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. ELIGIBILITY DATA

Indicate the method by which you qualify for the Opticianry Examination:

Completed the Apprenticeship Program / Registered Apprentice Number DA _____

Associate Degree in Opticianry.

Licensed by examination in another state, territory, or jurisdiction of the United States.

Practiced over five years in an unlicensed state, territory, or jurisdiction of the United States.

* 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.

The practice location address must be a street 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



Opticianry Application For Licensure Examination (2001)

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. ELIGIBILITY DATA

Indicate the method by which you qualify for the Opticianry Examination:

- Completed the Apprenticeship Program / Registered Apprentice Number DA _____
- Associate Degree in Opticianry.
- Licensed by examination in another state, territory, or jurisdiction of the United States.
- Practiced over five years in an unlicensed state, territory, or jurisdiction of the United States.

* 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.

The practice location address must be a street 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 LICENSURE STATUS

A. Do you hold or have you ever held a license, certificate, or registration to practice Opticianry in any state (including Florida), territory, or jurisdiction of the United States, or foreign country? YES NO
 If YES, list all licenses, certificates, and/or registrations and the issuing state, territory, or foreign country. Each issuing state, territory, or foreign country must submit a license/certificate/registration verification form.

TYPE OF LICENSE/CERTIFICATE	ISSUING STATE, TERRITORY, FOREIGN COUNTRY

B. Do you have any applications for licensure, certification, or registration in Opticianry currently pending in any state (including Florida), U.S. territory, or foreign country? YES NO
 If YES, list all pending applications and the issuing state, territory, or foreign country:

5. PROFESSIONAL EXPERIENCE

Starting with the most recent experience, list below all work experience. Attach additional sheets if necessary.

Dates of Experience From M/D/Y To M/D/Y Explain all breaks in experience	Place of Employment and Address (actual location where you worked)	Duties Performed
1. _____ _____	1. _____ _____ _____	1. _____ _____ _____
2. _____ _____	2. _____ _____ _____	2. _____ _____ _____
3. _____ _____	3. _____ _____ _____	3. _____ _____ _____
4. _____ _____	4. _____ _____ _____	4. _____ _____ _____
5. _____ _____	5. _____ _____ _____	5. _____ _____ _____
6. _____ _____	6. _____ _____ _____	6. _____ _____ _____
7. _____ _____	7. _____ _____ _____	7. _____ _____ _____

6. 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?	<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 6, you must provide the Board complete details.		
7. 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 7, 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 licensure denial.		

8. 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 |

9. 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



LICENSE/CERTIFICATE/REGISTRATION VERIFICATION FORM

I am applying for licensure in the State of Florida. The Florida Board of Opticianry requires verification of licensure by each jurisdiction in which I hold or have ever held a license. Please complete Part II and return to the Florida Board of Opticianry at the address below.

PART I: TO BE COMPLETED BY THE APPLICANT.

Complete this part and submit to each state where you hold or have ever held a license to practice Opticianry.

Applicant Name (please print): _____

Address/City/State/Zip: _____

License/Certificate Number: _____ State of: _____

Applicant's Signature _____ Date: _____

PART II: TO BE COMPLETED BY AN OFFICIAL OF THE REGULATORY BOARD AND RETURNED TO THE ADDRESS BELOW

Licensee's Name: _____ Profession: _____

License/Certificate Number: _____ Original Issue Date: _____

License/Certification Status: _____ Expiration Date: _____

Is there any time period when this license was not active for any reason? YES NO

If Yes, please list the beginning and ending dates of non-active periods and the reasons.

Do you have any disciplinary action information on file regarding this licensee? YES NO

If this license was ever revoked, suspended or otherwise acted against, please provide a copy of the action(s) with this form when it is returned.

Board/State Seal Verified by: _____

Signature of Official

Printed Name and Title

Name of State

Date Signed

Please return this form to: Florida Board of Opticianry
4052 Bald Cypress Way, Bin C 08, Tallahassee, FL 32399-3258



EXAMINATION APPLICATION CHECKLIST

The following items must be received in order for your application to be complete:

MAILED BY THE APPLICANT:

- _____ Completed and signed application
- _____ Check or money order in the amount of \$670.00
- _____ Two 2" x 2" recent passport-style photos
- _____ Photocopy of current ABO certification or proof of passing the ABO examination within three years of application
- _____ Photocopy of current NCLE certification or proof of passing the NCLE examination within three years of application
- _____ Photocopy of High School diploma or equivalency
Registered apprentices do not need to submit this
- _____ Detailed explanation and required documentation for any "Yes" answers to history questions
- _____ Documentation showing proof of five years Opticianry practice within the last 7 years, if you are qualifying by this method

MAILED BY THE ORIGINATING SOURCE:

- _____ License/Certificate/Registration Verification Form from each state where you hold or have ever held a license, certificate, or registration
- _____ Official transcript showing Associate Degree in Opticianry was earned, if you are qualifying by this method