



*Board of Opticianry*

*Re-Examination  
Application*

## **GENERAL INFORMATION**

### **MAIL YOUR RE-EXAMINATION 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.

Please read the application instructions before completing the application and forms. We suggest you keep a copy of the completed re-examination 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](http://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. All are accessible at the Opticianry Web site listed above then clicking on "Laws and Rules".

## **Opticianry Re-Examination Application Instructions**

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 made out to the Department of Health for \$100.00 **plus** the examination fee for the part(s) you are requesting to retake. The \$100 application fee is non-refundable.

Practical=\$560

Neutralization=\$190

Dispensing Problems=Fee Paid to Testing Center

### **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 RE-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. Examination History:** List the date of your original examination. If you have re-taken one or more portions of the examination, list the date of your examination re-take.
- 3. Examination Portion(s) You Are Applying to Re-Take:** Check the appropriate box(es).
- 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 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.

- 6. Applicant Statement.** Read this entire section. Your original signature is required.



## Opticianry Re-Examination Application (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 change(s):

\_\_\_\_\_

\_\_\_\_\_

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. EXAMINATION HISTORY

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

### 3. EXAMINATION PORTION(S) YOU ARE APPLYING TO RE-TAKE

Neutralization (\$190)       Practical (\$560)       Dispensing Problems (Fee Paid to Testing Center)

Submit application fee of \$100 plus the amount(s) for part(s) checked above.

\* 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 Re-Examination Application (2001)

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

Name	Last	First	Middle	<b>DO NOT WRITE IN THIS SPACE FOR OFFICE USE ONLY</b>
Mailing Address	No. and Street .		Apt. No.	
	City	State	Zip Code	
* Practice Location Address	No. and Street		Apt. No.	
	City	State	Zip Code	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 \_\_\_\_\_

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Photo must be professional quality showing only the head and shoulders.  
Print name on back of photo

<b>4. APPLICANT HISTORY – PROFESSIONAL</b>	
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 a 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.	
<b>5. APPLICANT HISTORY – GENERAL</b>	
A. 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 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 licensure denial.	

## 6. 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

