Attach a
Current Full
Faced Photograph

1313-001 -$ 260
1313-006 -$ 10
$ 270

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH REALTED BOARDS
665 MAINSTREAM DR
NASHVILLE, TN 37243

TENNESSEE BOARD OF DISPENSING OPTICIAN
(615) 253-6061 or TOLL FREE (800) 778-4123
http://tn.gov/health/topic/DO-board

APPLICATION FOR LICENSE AS A DISPENSING OPTICIAN

INSTRUCTIONS

1. Complete this application, have it notarized, enclose a non-refundable check for Two Hundred Seventy Dollars ($270) payable to the Board of Dispensing Opticians, and mail to the above address.

2. Provide proof of graduation from high school or general equivalency diploma (G.E.D.)

3. Attach a "passport" size photograph taken within the preceding twelve (12) months to the front of the application.

4. Attach an original or notarized photocopy of your birth certificate.

5. Attach proof of your A.B.O./N.C.L.E. certification to the application..

6. Attach at least two (2) letters of recommendation to the application. At least one (1) letter must be from a current or former employer.

7. If you are or have ever been licensed, certified, registered, or permitted by any state to practice as a dispensing optician (or as any other health care professional), you must request a verification from each and every state. The verification must be mailed directly to the Board's Office from the other state(s).

8. You must put your social security number on this form for the application to be complete. State and federal law require social security numbers on this application. Tenn. Code. Ann. § 36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity, to ask questions about your financial responsibility, and for any other purpose allowed by state or federal law. When you provide your social security number on this application and sign the form, you are agreeing that Department of Health may use your social security number in furtherance of federal and state law, for example, to collect delinquent fees.

9. You must fill out and have notarized the Declaration of Citizenship form found at: http://tn.gov/assets/entities/health/attachments/PH-4183.pdf

10. Complete and submit the Practitioner Profile Questionnaire which is online at: http://tennessee.gov/assets/entities/health/attachments/PH-3585.pdf
You are required by law to update your profile within thirty (30) days of any change as long as you have an active license. Failure to do so may subject you to disciplinary action.

11. A criminal background check is required. For instructions to obtain a criminal background check, see: https://www.tn.gov/health/health-professionals/criminal-background-check.html

CATEGORY OF APPLICATION: SELECT ONE

_____ 1. Graduate of a two (2) year Opticianry school. (Have a transcript sent directly from your school to us.)
_____ 2. Completed the three (3) year Tennessee Apprenticeship program.
_____ 3. Completed three (3) years apprenticeship training from another licensing state; or licensed in a licensing state whose qualifications for licensure are equivalent or greater than Tennessee's.

Name _____
Last **First** **Middle and/or Maiden**

Date of Birth _____ **Social Security Number** _____

U.S. Citizen: Yes_____ No_____ All applicants must complete the Declaration of Citizenship form and have it notarized.

Current Home Mailing Address:

_____

_____

_____

Current Practice Name & Address:*

_____

_____

_____

***If you have no practice address, notify the Board of your practice address within 30 days of obtaining a practice address. If you have multiple practice address, please attach an additional page listing all practice addresses.**

Home Phone _____ **Work Phone** _____

E-Mail:_____

Do you wish to receive notifications, including renewal notification, from Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. ____ **Yes** ____ **No**

Gender: Female _____ **Male** _____ **Race:** _____

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.) **Yes** ____ **No** _____

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.)

Yes ____ **No** _____

Have you ever been known by any other names besides what is listed above? **Yes** ____ **No** _____

If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known:

_____

_____

CERTIFICATION OF EXPERIENCE IN OPHTHALMIC DISPENSING

Complete this form for every location you have worked in Ophthalmic dispensing. Make as many copies of this page as necessary.

NAME OF EMPLOYER

ADDRESS OF EMPLOYER

CITY STATE ZIP

TELEPHONE NUMBER NAME OF DIRECT SUPERVISOR

Employed in Position from _____, _____ to _____, _____.

TYPE OF ESTABLISHMENT OR OFFICE

_____ Ophthalmic Dispenser
_____ Contact Lens Manufacturer
_____ Contact Lens Technician
_____ Ophthalmologist's Office
_____ Other (specify) _____
_____ Wholesale Distributor
_____ Optometrist's Office
_____ Optician

CHECK THE SPECIFIC DUTIES PERFORMED IN THE ABOVE POSITION AND GIVE APPROXIMATE PERCENTAGE OF TIME ENGAGED IN EACH DURING A NORMAL WORK WEEK. TOTAL PERCENTAGE SHOULD ACCOUNT FOR 100% OF HOURS WORKED. FILL IN EACH LINE.

%	DUTIES PERFORMED
	Fitting and adjusting lenses to human faces
	Fitting contact lenses
	Interpreting prescriptions and making optical calculations
	Verifying
	Optical laboratory work
	Selling merchandise (other than ophthalmic materials)
	Stock work
	Office work
	Describe other duties not listed (managerial, etc.)

Please complete your entire healthcare employment history starting with the most current position first. Use the back of this page, if you need additional space. Dates of employment must be included.

Company/ Employer:	Address: (City, and State)	Position:	Duties:	Dates From: Mo./Yr.	Dates To: Mo./Yr.

	YES	NO
Are you or have you ever been licensed in this profession in another state?		
Are you or have you ever been licensed in any other profession in Tennessee or another state?		

List below **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED**. Additional pages may be added if necessary. Request that verification of licensure be submitted directly to the Board's Office from each state.

STATE	PROFESSION	LICENSE NUMBER	CURRENT STATUS

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION. Additional information may be requested and/or required before a licensure decision may be made. For the purposes of these questions, the following phrases or words have the following meanings:

1. "**Ability to practice as a Dispensing Optician**" is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate clinical diagnosis, exercise reasoned judgments, to learn, and keep abreast of dental developments;

b. The ability to communicate those judgments and dental information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

c. The physical capability to perform dental tasks such as examinations and dental procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. "**Medical Condition**" includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction, and alcoholism.

3. "**Minor Traffic Offense**" generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under intoxication or reckless driving.

4. "**Chemical substances**" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

5. "**Currently**" does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

6. "**Illegal use of illicit or controlled substances**" means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.

		YES	NO
1.	Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice?	_____	_____
2.	Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety?	_____	____

If so, please list: _____

[*If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical conditions so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are ineligible for licensure.]*

3.	At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	_____	_____
4.	Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?	_____	_____
5.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?	_____	_____

YES **NO**

6. Have you ever held or applied for a license, privilege, registration or certificate to practice as a hearing aid dispenser in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action? _____ _____

7. Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action? _____ _____

8. Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action? _____ _____

9. Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended? _____ _____

10. Have you ever been rejected or censured by a professional association or society? _____ _____

11. In relation to the performance of your professional services in any profession:
    a. Have you ever had a final judgment rendered against you; _____ _____

    b. Have you ever entered into any settlement of any legal action; or _____ _____

    c. Are there any legal actions pending against you or to which you are a party? _____ _____

12. Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction? _____ _____

13. My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state) _____ _____

AFFIDAVIT AND RELEASE

I, _____, of _____, being duly sworn
(Applicant's Name) (City) (State)
and identified as the person referred to in this application, attest to the truth of each statement made in said application. I further attest that I have read and understand the law and the rules and regulations regarding the practice of my profession, which are posted on the Board's internet site and/or were provided to me by the Board office, and agree to abide by them in the practice of dispensing opticianry in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice Speech Pathology/Audiology.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications;

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character and other qualifications for certification.

ACKNOWLEDGE that I, as an applicant for certification, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ ____ _____
SIGNATURE **DATE**