

# Optician Apprentice Application for Registration



**Board of Opticianry**  
**P.O. Box 6330**  
**Tallahassee, FL 32314-6330**  
**Website: [www.floridasopticianry.gov](http://www.floridasopticianry.gov)**  
**Email: [MQA.Opticianry@flhealth.gov](mailto: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>



**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](http://www.ssa.gov) or by calling 1-800-772-1213.

Name: \_\_\_\_\_

**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.

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](mailto: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 License #: \_\_\_\_\_

Optician    Board Certified Optician    Optometrist    Allopathic Physician    Osteopathic Physician

Secondary

Sponsor Name: \_\_\_\_\_ Secondary Sponsor License #: \_\_\_\_\_

Optician    Board Certified Optician    Optometrist    Allopathic Physician    Osteopathic Physician

**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 substance-related (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?
				Y   N
				Y   N
				Y   N
				Y   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?
				Y   N
				Y   N
				Y   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.







**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



## 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 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.*

### **Apprentice Information**

Apprentice Full Name: \_\_\_\_\_

Number of hours this apprentice will work per week under direct supervision of a sponsor: \_\_\_\_\_

### **Primary Sponsor General Information**

Sponsor Name \_\_\_\_\_ Business Name \_\_\_\_\_

Address/City/State/ZIP \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax \_\_\_\_\_

Primary Sponsor License # \_\_\_\_\_ Profession \_\_\_\_\_

Rule 64B12-16.003, F.A.C., requires the apprentice to complete training in filling, fitting and adapting contact lenses by a Florida board-certified optician, a Florida licensed optometrist, a Florida licensed allopathic physician, or a Florida licensed osteopathic physician. Will this training be provided by the primary sponsor?

Yes No **(You must check one.)**

### **Secondary Sponsor General Information (if applicable)**

Secondary Sponsor Name \_\_\_\_\_ Business Name \_\_\_\_\_

Address/City/State/ZIP \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax \_\_\_\_\_

Secondary Sponsor License # \_\_\_\_\_ Profession \_\_\_\_\_

Rule 64B12-16.003, F.A.C., requires the apprentice to complete training in filling, fitting and adapting contact lenses by a Florida board-certified optician, a Florida licensed optometrist, a Florida licensed allopathic physician, or a Florida licensed osteopathic physician. Will this training be 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: \_\_\_\_\_

I state that I dispense eyewear and maintain all of the equipment required by Rule 64B12-10.007, F.A.C., on the same premises where the apprentice works. I further state that my apprentice and I have reviewed, **together**, ch. 484, Part I, Florida Statutes, and Rule 64B12-16, F.A.C. I declare that I fully understand my responsibilities to my apprentice and to the Board of Opticianry and the Department of Health, as a properly registered sponsor of an apprentice registered in the opticianry apprenticeship program.

\_\_\_\_\_  
Primary Sponsor Signature

\_\_\_\_\_  
Date (MM/DD/YYYY)

\_\_\_\_\_  
Secondary Sponsor Signature (if applicable)

\_\_\_\_\_  
Date (MM/DD/YYYY)