# Optical Establishment Application for Permit

Florida HEALTH
Medical Quality Assurance

Department of Health
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: floridasopticianry.gov
Email: info@floridasopticianry.gov
Phone: (850) 245-4292
Fax: (850) 413-6982

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**P.O. Box 6330**
**Tallahassee, FL 32314-6330**
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**Do Not Write in this Space**
**For Revenue Receipting Only**

**Select application type:**
*A separate application must be filled out for each individual establishment. Change of ownership requires a new registration.*

- ☐ **New Optical Establishment Permit** — **$100.00** (application fee)
- ☐ **Change of Physical Location** — **$25.00** (duplicate license fee)
- ☐ **Change of Establishment Name** — **$25.00** (duplicate license fee)

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. Application fees and duplicate license fees are non-refundable.

## 1. ESTABLISHMENT AND OWNER / AGENT INFORMATION

**Name of Establishment:** _____

**Physical Location:** (Address where the establishment is located. This address will be posted on the Department of Health's website)

_____ _____ _____
Street Suite No. City

_____ _____ _____ _____
State ZIP County-required Establishment Telephone-required (Input without dashes)

_____ _____
Name of Contact Person Name of Licensed Optician

**If applying for a Change of Physical Location, provide the establishment's previous address:**

_____ _____ _____
Street Suite No. City

_____ _____ _____
State ZIP County

**Name of Owner/Agent:** _____

**Owner/Agent Mailing Address:** _____ _____
Street Apt. No.

_____ _____ _____ _____
City State ZIP Owner/Agent Telephone (Input without dashes)

**Email Notification:** To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the department.

☐ Yes ☐ No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

## 2. OWNER / AGENT SOCIAL SECURITY DISCLOSURE (REQUIRED)

**This information is exempt from public records disclosure.**

Pursuant to 42 U.S.C. § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, s. 456.013(1)(a), F.S., authorizes the collection of Social Security numbers as part of the general licensing provisions.

**Owner/Agent Last Name: _____**

**Owner/Agent First Name: _____**

**Owner/Agent Middle Name: _____**

**Owner/Agent Social Security or FEID Number: _____**
(Input without dashes)

**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 U.S.C., §§ 653 and 654; and ss. 456.013(1), 409.2577, and 409.2598, F.S. 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 or by calling 1-800-772-1213.

Name: _____

## 3. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

**IMPORTANT NOTICE:** Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under ch. 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control), or a similar felony offense(s) in another state or jurisdiction? ☐ Yes ☐ No

**If you responded "No" to the question above, skip to question 2.**

   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? ☐ Yes ☐ No

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S)? ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation?
   ☐ Yes ☐ 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," provide supporting documentation)?
   ☐ Yes ☐ No

2. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? ☐ Yes ☐ No

**If you responded "No" to the question above, skip to question 3.**

   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? ☐ Yes ☐ No

3. Has the applicant or any principal, officer, agent, managing employee, or affliated person of the applicant ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.?
   ☐ Yes ☐ No

**If you responded "No" to the question above, skip to question 4.**

   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? ☐ Yes ☐ No

Name: _____

4. Has the applicant or any principal, officer, agent, managing employee, or affliated person of the applicant ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? ☐ Yes ☐ No

**If you responded "No" to the question above, skip to question 5.**

a. Have you been in good standing with a state Medicaid program for the most recent five years? ☐ Yes ☐ No

b. Did termination occur at least 20 years before the date of this application? ☐ Yes ☐ No

5. Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? ☐ Yes ☐ No

a. If "Yes" to 5, is the applicant, principal, officer, agent, managing employee, or affiliated person of the applicant listed because the individual defaulted or is delinquent on a student loan? ☐ Yes ☐ No

b. If "Yes" to 5.a., is the student loan default or delinquency the only reason the individual is listed on the LEIE? ☐ Yes ☐ No

**If "Yes" responses were provided to any of the questions in this section, the following must be provided:**

☐ **Written self-explanation(s)** 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** including court dispositions or agency orders where applicable.

**Documentation must be mailed to:**

**Department of Health**
**Optical Establishments**
4052 Bald Cypress Way Bin C-08
Tallahassee, FL 32399-3257

## 4. OWNER / AGENT SIGNATURE

I have carefully read the questions in the foregoing application and have answered them accurately and completely. I confirm that these statements are true and correct and understand that providing false information may result in disciplinary action pursuant to s. 456.067, F.S., or criminal penalties pursuant to s. 775.082, s. 775.083, or s. 775.085, F.S. I understand that any false information provided on this application may constitute cause for denial, suspension, or revocation of any license to practice in the state of Florida.

I further state that I am familiar with the laws and rules regulating optical establishments and confirm that this facility meets the requirements of ch. 484, Part I, F.S., and the Rules of the Department of Health, in Rule 64B29, F.A.C., and that this facility will be operated in compliance with all applicable laws and rules.

I understand that it is my responsibility to keep informed of any changes to ch. 456 and 484, Part I, F.S., and Rule 64B29, F.A.C.

Owner/Agent Signature _____ Date _____
*You may print out the application and sign it or sign digitally.* MM/DD/YYYY