1812-001	$250
1812-006	10

TENNESSEE BOARD OF OPTOMETRY
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

LOCAL (615) 741-5735 - TOLL FREE (800) 778-4123

APPLICATION FOR LICENSE AS AN OPTOMETRIST

1. Complete this application, have it notarized, enclose a non-refundable check for Two Hundred Sixty Dollars ($260) payable to the Board of Optometry, and mail entire package to the above address.
2. Attach a recent passport style photograph to the front of this application.
3. Submit a notarized photocopy of a birth certificate (please do not send your original).
4. All applicants must complete the attached Declaration of Citizenship form.
5. Attach or have sent two (2) letters of reference from Optometrists written on the signatory's letterhead stationary. These letters must verify your good moral character.
6. Have your school of optometry or accredited college remit a transcript directly to this office.
7. Have N.B.E.O. remit your national exam scores directly to this office. (If you requested this when you took your exams, the scores should have already been sent but it is your responsibility to follow up and verify that we still have this information.)
8. Submit a copy of your current CPR card
9. If you have ever been licensed in another state, complete page 4
10. Submit a copy of the Mandatory Practitioner Profile (http://tn.gov/assets/entities/health/attachments/PH-3585.pdf)
11. Submit a copy of the Law and Ethics exam which will be mailed after receipt of the application.
12. A Criminal Background Check is required. For instructions go to: (http://health.tn.gov/CBC/)

NAME_____
First **Middle and/or Maiden** **Last**

DATE OF BIRTH _____ **Social Security #**_____

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.

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

CURRENT HOME MAILING ADDRESS: **CURRENT PRACTICE NAME & ADDRESS:**

_____ _____

_____ _____

_____ _____

HOME PHONE _____ **PRACTICE PHONE** _____

E-MAIL ADDRESS: _____

Do you wish to receive notifications, including renewal notification, from the Department of Health via email?
____ **Yes** ____ **No**

List all states where you currently have or have ever had an Optometrist License:

_____ _____ _____ _____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the affirmative, attach an explanation on a separate sheet. 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. For the purpose of these questions, the following phrases or words have the following meanings:

1. ***"Ability to practice as an Optometrist"*** is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate diagnosis (if necessary), exercise reasoned judgment, and to learn and keep abreast of development in the field.

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

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

2. ***"Medical Condition"*** includes physiological, mental or psychological disorders, such as, but not limited to: orthopedic, visual, speech and/or hearing impairment, cerebral palsy, epilepsy, muscular dystrophy, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

3. ***"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.

4. ***"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 use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

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

QUESTIONS	YES	NO
Do you currently have a medical condition which in any way impairs or limits your ability to practice as an Optometrist with reasonable skill and safety?	___	___
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	___	___
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner, in which you have chosen to practice?	___	___
(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 condition so as to determine whether conditions should be imposed or whether you are not eligible for licensure.)		
Do you currently use chemical substances?	___	___
If yes, do they in any way limit your ability to practice optometry with reasonable skill and safety?	___	___
Are you currently engaged in the illegal use of controlled substances?	___	___
If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaged in illegal use of controlled substances?	___	___
Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	___	___
If you have ever held or applied for a license or certificate to practice as a Optometrist in any state, county, or province, was or has it ever been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
If you have ever had staff privileges at any hospital or health care facility, have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	___	___
Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	___	____
Have you ever been rejected or censured by a Professional Association?	___	___
In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered <u>against</u> you?	___	___
b. Have you ever had settlement of any legal action rendered <u>against</u> you?	___	___
c. Are there any legal actions pending <u>against</u> you or to which you are a party?	___	___
If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___

AFFIDAVIT OF APPLICANT

Under penalty of perjury, I declare and affirm that the statements made in this application, including accompanying statements and transcripts are true, complete, and correct. I understand that any false or misleading information in or in connection with my application may be cause for denial or loss of my license.

I further swear that I have read and understand the statutes and the Rules and Regulations, which were enclosed in the application packet, and agree to abide by them while licensed by Tennessee.

_____
Signature of Applicant

Sworn to and subscribed before me this ____ day of _____, 20 _____.

Commission Expires: _____ _____
(Notary Public Signature)

(Notary Seal)

Tennessee Board of Optometry
665 Mainstream Drive
Nashville, Tennessee 37243

Local (615) 741-5735
Toll Free (800) 778-4123

CLEARANCE FROM OTHER STATE OPTOMETRY LICENSING BOARDS

Please complete the top portion and mail this form to the regulatory board in each state where you hold or have held a license to practice as an Optometrist. (If additional forms are required, this form may be duplicated.)

NOTE: Some states require a fee for providing clearance information. In order to expedite your application, you may wish to contact the applicable state or states.

****

I was granted _____ on _____ by the State of _____
Lic. # Date

The Tennessee Board of Optometry requests that I submit evidence that my certificate in your state is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Optometry.

Date: _____ Signature: _____

SSN# _____ Printed Name: _____

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THIS PORTION IS TO BE COMPLETED BY STATE LICENSING BOARD

License Number: _____ Date Issued: _____

Basis of Issuance: Endorsement/Reciprocity With: _____
Written Examination _____
(Provide Description of Exam)

License currently registered: _____ Yes _____ No

Derogatory Information on File _____ Yes _____ No
If "yes", please attach explanation.

_____ _____ _____
Authorized Signature Title Date

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) _____ _____.
Healthcare Profession (Please Print) License number if applicable

Please Print Legibly

1. Name:_____
   Last First Middle Maiden_
2. Mailing Address: _____
3. Phone Number: Home: (____)_____-_____ Office: (____)_____-_____ Fax: (____)___-_____
4. I am a United States Citizen: ____Yes ____No
5. I am a foreign national not physically present in the United States _____Yes _____No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide **one** of the following:
   a) Tennessee Driver's License, or photo ID issued by Department of Safety.
   b) A valid driver license or ID issued by another state, provided its issuance requirements meet Department of Safety criteria.
   c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
   d) A federally issued birth certificate.
   e) A valid, unexpired U.S. passport.
   f) A report of birth abroad of a U.S. citizen.
   g) A certificate of citizenship.
   h) A certificate of naturalization.
   i) A U.S. citizen ID card.
   j) Any successor document to #'s a-i above.
   k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.
7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
   a) Permanent Residents

b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).

c) Asylees who meet the qualifications set out in 8 U.S.C. 1158

d) Refugees who meet the qualifications set out in 8 U.S.C. 1157

e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.

f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980

g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.

h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status– "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this _____ day of _____, 20__.

_____
Signature

Sworn to before me this _____day of _____, 20__.

_____ AFFIX SEAL HERE
NOTARY PUBLIC

My Commission Expires:_____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.