

## APPLICATION BY ENDORSEMENT INSTRUCTIONS

Please thoroughly review these materials before submitting your application. All application fees are non-refundable. The Board reserves the right to reject any outdated applications submitted. Incomplete applications will be destroyed after six months of inactivity.

A completed application file consists of:

1. Completed and notarized **Application by Endorsement** with fee of \$160.00. **FEE IS NON-REFUNDABLE.**
2. Results of all NBEO Examinations completed must be sent direct from NBEO.
3. Certified undergraduate transcripts sent directly from school.
4. Certified transcript showing OD degree sent directly from school.
5. License verification form from all states where you are or have been licensed.
6. Copy of legal document supporting a legal name change.
7. MN Law Examination with passing score.
8. Documentation for "Use of Legend Drugs"

### Level Licensure Statement

As of January 1, 2013, all Minnesota Licensed Optometrists meet therapeutic certification standards (TPA) and are considered as meeting nationally recognized TMOD requirements. This level licensure standard is all inclusive of any former education including, but not limited to DPA, TPA certifications if the Minnesota licensed O.D. is currently or initially licensed after January 1, 2013. One license certificate is issued which encompasses DPA, TPA and full licensure as a Minnesota Licensed Optometric Doctor, O.D.

### QUESTIONS

If you have specific questions about the application process, please call 651-201-2762, fax 651-201-2763, or email [optometry.board@state.mn.us](mailto:optometry.board@state.mn.us)

Address all written correspondence to:

State of Minnesota  
Board of Optometry  
2829 University Avenue SE, Suite 403  
Minneapolis, MN 55414-3245

# STATE OF MINNESOTA BOARD OF OPTOMETRY APPLICATION BY ENDORSEMENT



UNIVERSITY PARK PLAZA  
2829 UNIVERSITY AVENUE SE, SUITE 403  
MINNEAPOLIS, MINNESOTA 55414-3245  
651-201-2762 or [www.optometryboard.state.mn.us](http://www.optometryboard.state.mn.us)  
email: [optometry.board@state.mn.us](mailto:optometry.board@state.mn.us)  
Hearing Impaired-Minnesota Relay Service 1-800-627-3529

1. Review complete instructions.
2. Answer all questions completely, accurately, and legibly or the application will be returned.
3. The name you enter must be your full legal name.
4. All addresses must include zip code if requested on the application.
5. Required fee of \$160.00 must accompany application. **FEE IS NON-REFUNDABLE.**
6. Failure to answer all questions completely and accurately, and/or an omission or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.
7. Attach additional sheet if necessary.
8. Review check list to assure application is complete prior to submission (Page 11 of the application)
9. Immediately inform the Board of any changes in application information.

### Application Date

\_\_\_\_\_

(month/day/year)

**TO: The Minnesota Board of Optometry:**

I hereby make application for a license to practice optometry in the State of Minnesota and submit the following statements.

#### YOUR CURRENT NAME AND ADDRESS

Full Legal Name (Last, First, Middle)		Previous Name, if changed	Gender
Street Address			
City	State or Province	Zip Code	Country
Contact Phone	Other Phone/Cell	Email	
Social Security or Alien Registration Number		OE Tracker Number	

#### FOR BOARD USE ONLY

Date Received _____	Check #: _____
Amt Paid: _____	Deposit #: _____
Returned (Incomplete/Incorrect Fees/Other):	

**APPLICANT'S RECORD OF BIRTH**

Date of Birth (Month/Day/Year)	City of Birth	State of Birth	Country of Birth
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**PRELIMINARY EDUCATION**

Name of High School	City	State/Province	From (Month/Year)	To (Month/Year)	Type of Degree
Name of College/University	City	State/Province	From (Month/Year)	To (Month/Year)	Type of Degree
Name of College/University	City	State/Province	From (Month/Year)	To (Month/Year)	Type of Degree
Name of College/University	City	State/Province	From (Month/Year)	To (Month/Year)	Type of Degree

**OPTOMETRY EDUCATION**

Name of College/University	City	State/Province	Date Degree Conferred
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**STATES/PROVINCES IN WHICH YOU ARE OR HAVE BEEN LICENSED**

You must have each state complete a license verification form.

State/Province	License #	Date Issued	Expiration Date

**PRACTICE LOCATIONS**

State below all places you have practiced, stating whether self-employed or employed.

Name of Facility, Address, & Phone Number	From (Month/Year)	To (Month/Year)	Self-employed/Employed?
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Name of Facility, Address, & Phone Number	From (Month/Year)	To (Month/Year)	Self-employed/Employed?
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Name of Facility, Address, & Phone Number	From (Month/Year)	To (Month/Year)	Self-employed/Employed?
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Name of Facility, Address, & Phone Number	From (Month/Year)	To (Month/Year)	Self-employed/Employed?
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## ACCOUNTING OF REQUIRED DATA

**Circle Yes or No.** Attach additional sheets to provide sufficient detail. For questions 1 and 2 below, the terms “impaired” and “limited” include but are not limited to impairments or limitations related to physical, psychological, or emotional disorders or conditions, or chemical dependency or chemical abuse. **If responses to questions change during the time your application is pending, you must make the Board aware of the new information.**

1. Is your cognitive, communicative, or physical ability to engage in practice as an optometrist with reasonable skill and safety been impaired or limited in any way? Please describe on a separate sheet.

**Yes No**

<b>1a.</b> If yes, are the limitations or impairments reduced or improved because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Please describe on a separate sheet.	<b>Yes</b>	<b>No</b>
<b>1b.</b> If yes, are the limitations or impairments reduced or improved because of the setting or the manner in which you have chosen to practice? Please describe on a separate sheet.	<b>Yes</b>	<b>No</b>

2. Does your use of alcohol or chemical substances(s), including prescription medications, in any way impair or limit your ability to practice as a optometrist with reasonable skill and safety? Please describe on a separate sheet.

**Yes No**

3. Are you engaged in any illegal use of controlled substances including use of illegal controlled substances (e.g. heroin, cocaine) or illegal use of legal controlled substances (i.e. not obtained pursuant to a valid prescription of a licensed health care provider). Please describe on a separate sheet.

**Yes No**

<b>3a.</b> If yes, have you taken any steps (i.e. treatment, psychotherapy, participation in a support group) to discontinue or reduce such use? Please describe on a separate sheet.	<b>Yes</b>	<b>No</b>
<b>3b.</b> If yes, are you now participating in a supervised rehabilitation program or professional assistance program which has as a component a monitoring regimen designed to assure that you are not currently engaging in the use of illegal controlled substances? Please describe on a separate sheet.	<b>Yes</b>	<b>No</b>

4. Have you within the past five years been advised by your treating physician that you have a mental, physical, or emotional condition, which, if untreated, would be likely to impair your ability to practice as an optometrist with reasonable skill and safety?

**Yes No**

If you answer this question “yes”, please answer the following:

<b>4a.</b> With regard to any condition referenced above, are you being treated so that such impairment is avoided?	<b>Yes</b>	<b>No</b>
<b>4b.</b> With regard to any condition referenced above, are you in compliance with the recommended treatment?	<b>Yes</b>	<b>No</b>
<b>4c.</b> With regard to any condition referenced above, has your treating physician advised you that you are able to practice as an optometrist with reasonable skill and safety?	<b>Yes</b>	<b>No</b>
<b>4d.</b> Please explain on a separate sheet.		
<b>4e.</b> Identify your treating physician:		

5. Have you ever been diagnosed as having or have you been treated for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders? If so, please describe on a separate sheet. **Yes No**
6. Have you ever been the subject of an investigation by any Federal, State, or Local agency having jurisdiction over controlled substances? If so, give particulars on a separate sheet. **Yes No**
7. Have you ever been denied licensure/registration by, or the privilege of taking an examination before any examining board, or has a conditioned license/registration ever been issued to you by any state board or other licensing authority? If so, give particulars on a separate sheet. **Yes No**
8. Has your license/registration to practice as an optometrist in any state or country ever been voluntarily or involuntarily revoked, suspended, restricted, or conditioned by a State Board or other licensing authority? If so, give particulars on a separate sheet. **Yes No**
9. Have you ever been notified of any investigations by any state board or any health facility of any complaints against you relative to the practice of optometry, or have you been reprimanded or censured by any licensing board? If so, give particulars on a separate sheet. **Yes No**
10. Have you ever been a defendant in any malpractice lawsuits, had any malpractice settlement, or have any pending? If so, give a detailed clinical explanation (on a separate sheet) of each case as well as documentation of outcome (insurance papers or court documents). **Yes No**
11. Have you ever been denied, restricted, or revoked staff affiliations with a hospital, nursing home, clinic, or other health care facility? If so, give particulars on a separate sheet. **Yes No**
12. Have there been any criminal charges filed against you? This includes charges of disorderly conduct, assault or battery, or domestic abuse, whether the charges were misdemeanor, gross misdemeanor, or felony. This also includes any offenses which have been expunged or otherwise removed from your record by executive pardon. If so, give particulars (on a separate sheet) including the date of conduct, state and local jurisdiction in which the charges were filed. **Yes No**
13. Have there been any charges of Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) or other impaired driving offenses involving alcohol or other chemicals filed against you? If so, give particulars, (on a separate sheet) including the date of conduct, state and local jurisdiction in which the charges were filed.

**Yes No**

**There are four requirements for therapeutic certification stated in MN Statute 148.575, Subd. 2, Paragraphs 1, 2, 3 and 4. Please read and complete the following.**

**1.) I meet the requirement of MN Stat. 148.575, Subd. 2, Para. 1, which requires 60 hours of Board approved study in general and ocular pharmacology. (check one or more)**

\_\_\_\_\_ I am a graduate from an approved school or college of optometry after August 1, 1982.

\_\_\_\_\_ I am currently certified to use diagnostic drugs in the State of Minnesota.

\_\_\_\_\_ I have attached course certification for 60 hours of approved study in general and ocular pharmacology. (DPA Course)

\_\_\_\_\_ My school/college of optometry has certified, on the form provided by the Board, that this education was included in my curriculum.

**2.) I meet the requirement of MN Stat. 148.575, Subd. 2, Para. 2, which requires 100 hours of board approved study in examining, diagnosis, and treatment of conditions of the human eye with legend drugs. (check one)**

\_\_\_\_\_ I am a graduate of an approved school of college of optometry after May 1, 1993.

\_\_\_\_\_ I have attached course certification of 100 hours of approved study in the use of legend drugs. (TPA course)

\_\_\_\_\_ My school/college of optometry has certified, on the form provided by the Board, that this education was included in my curriculum.

**3.) The Minnesota Board of Optometry has determined that all applicants will meet the requirement of MN Stat. 148.575, Subd. 2, Para. 3. No documentation is necessary.**

**4.) I meet the requirement of MN Stat. 148.575, Subd. 2, Para. 4, which requires passing a nationally standardized examination on the treatment and management of ocular disease such as the IAB or NBEO TMOD exam. (check one)**

\_\_\_\_\_ I have attached a copy of the certificate issued by the IAB or NBEO certifying successful completion of an examination in the treatment and management of ocular disease.

\_\_\_\_\_ My examination score report for the TMOD examination has been sent to the Minnesota Board of Optometry office by IAB or NBEO.

**TENNESSEN WARNING (Minn. Stat. § 13.04)**

The Minnesota Board of Optometry is seeking data from you which may be considered private or confidential under the Minnesota Government Data Practices Act, Minn. Stat. Â§ 13.01 et seq. Minn. Stat. Â§ 13.04, subd. 2 requires the Board to notify you of the following four matters before you are asked to supply such information about yourself: (1) This data is being collected to determine whether you meet the requirements for licensure as well as whether you have violated any statutes or rules the Board is empowered to enforce; (2) You are not legally required to provide this information, but failure to do so may result in the denial of this licensure application; (3) If you supply the data requested and it shows a violation of any of the statutes or rules enforced by the Board, you may be subject to disciplinary or other action by the Board. If you refuse to supply the data requested, your licensure application may be denied. In addition, falsification or omission of information may be used by the Board as a basis for disciplinary action; and (4) the data which you supply will be accessible to Board staff. The data you supply may also be released to other persons and/or governmental entities that have statutory authority to review the data, investigate specific conduct, and/or take appropriate legal action. If the Board institutes a formal disciplinary action against you, the information you supply could become public.

**RIGHTS OF SUBJECTS OF DATA**

This application is authorized by MN Stat. 148.57 and will be used to determine your qualifications for licensure. Although you may refuse to supply the information requested in this application, failure to provide the requested information will result in the denial of licensure.

**AFFIDAVIT OF APPLICANT:**

State of: \_\_\_\_\_

County of: \_\_\_\_\_

I, \_\_\_\_\_, swear that I am the person described and identified; that I have not engaged in any of the acts prohibited by the statutes of Minnesota.

I hereby authorize all educational institutions, hospitals, medical institutions or organizations, clinics, my references, personal physicians, employers (past and present), business and professional associates (past and present), all governmental agencies and instrumentalities (local, state, federal or foreign) to release to this licensing Board any information, files, or records including (but not limited to) transcripts, medical records, personnel files, and any information, favorable or otherwise, the Board may require for its evaluation of my professional, ethical, and physical qualifications for licensure in Minnesota.

I hereby release, discharge, and exonerate the Board, its agents, and representatives, and any person furnishing information to the Board from any and all liability of every nature and kind arising out of the furnishing of oral information or of documents, records, or other information to the Board.

I have carefully read the questions in the in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my license to practice optometry in Minnesota. I understand that I am required to update my application with pertinent information to cover the time period between date of application and date approved by the Board.

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Signature of Notary Public

My Commission Expires: \_\_\_\_\_

# MINNESOTA BOARD OF OPTOMETRY

2829 University Avenue SE, Suite 403, Minneapolis, MN 55414  
(651) 201-2762

## OPTOMETRY LICENSE CERTIFICATE

Please complete this form, with the requested information, for the printing of your official license to practice optometry in the State of Minnesota.

I would like the following information to appear on my Minnesota Optometry License:

Name \_\_\_\_\_ O.D.

PLEASE PRINT

A letter, wall certificate and license card will be mailed to you after your application is reviewed and license issued, indicating the license number assigned to you. This documentation will serve as evidence that you have met the licensure requirements of the State of Minnesota and have the authority to practice optometry in the State of Minnesota.

# MINNESOTA BOARD OF OPTOMETRY

2829 University Avenue SE, Suite 403  
Minneapolis, MN 55414  
(651) 201-2762

## REQUEST FOR LICENSE VERIFICATION

**APPLICANT:** Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting verification of your license.

Applicant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**LICENSING JURISDICTION:** Return completed form directly to the Minnesota Board of Optometry at the address listed above.

License #: \_\_\_\_\_ Date Issued: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Current License Status: Active \_\_\_\_\_ Inactive \_\_\_\_\_ Lapsed \_\_\_\_\_ Other \_\_\_\_\_

Licensed by: National Board Examinations \_\_\_\_\_  
State Examination(s) \_\_\_\_\_ Written \_\_\_\_\_ Practical \_\_\_\_\_  
Waiver \_\_\_\_\_  
Reciprocity/Endorsement \_\_\_\_\_ From which state \_\_\_\_\_

If licensed by state examination, provide subjects and scores.

SUBJECT	SCORE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Has this license ever been revoked, suspended, surrendered, restricted, limited, or placed on probation?

NO \_\_\_\_\_ YES \_\_\_\_\_ IF YES, PLEASE EXPLAIN ON REVERSE SIDE OR PROVIDE COPIES OF DISCIPLINARY ACTION TAKEN.

Is applicant currently under investigation or charged with a violation of the practice act?

NO \_\_\_\_\_ YES \_\_\_\_\_ IF YES, PLEASE EXPLAIN ON REVERSE SIDE.

### FORM COMPLETED BY:

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
DATE

STATE SEAL

# CERTIFICATION BY SCHOOL/COLLEGE OF OPTOMETRY

I, \_\_\_\_\_, am an applicant for "Board Certification" to use legend drugs in the State of Minnesota.

I hereby authorize the \_\_\_\_\_ to furnish to the Minnesota Board of Optometry the information requested below.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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The applicant named above successfully completed at least 60 hours of study in general and ocular pharmacology emphasizing drugs used for examination or treatment purposes, their systemic effects and management or referral of adverse reactions through their optometric curriculum.

\_\_\_\_\_ YES    \_\_\_\_\_ NO

The applicant named above successfully completed at least 100 hours of study in the examination, diagnosis, and treatment of conditions of the human eye with legend drugs through their optometric curriculum.

\_\_\_\_\_ YES    \_\_\_\_\_ NO

**I certify that the information contained herein is true and correct according to the official records of this school/college.**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
School/College

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

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

**RETURN THIS FORM TO:**

Minnesota Board of Optometry  
2829 University Avenue SE, Suite 403  
Minneapolis, MN 55414

# Application Check List

For applicant use, do not submit to the Board

- Page 1:
  - All information complete?
  - Legal documentation of name change is required.
  - Note: The email address (optional) allows the Board to email application file updates on an as needed basis.
- Page 2:
  - All information provided?
- Pages 4 & 5: Questions 1 – 13 complete? Any other documentation needed?
- Pages 6: Questions for “Use of Legend Drugs”? **YOU CANNOT BE LICENSED UNLESS YOU MEET THE REQUIREMENTS FOR THE USE OF LEGEND DRUGS.**
- Page 7: Affidavit of Applicant
  - Read and understand *Rights of Subjects of Data* and *Affidavit of Applicant*.
  - Applicant Signature
  - Notarized
- Application Fee (\$160). If the fee that accompanies the application is incorrect, the entire application will be returned.
- Request license verification from all jurisdictions where a license has been issued.

Applicant Notes: