

MINNESOTA BOARD OF OPTOMETRY

2829 University Avenue SE, Suite 403
Minneapolis, MN 55414
(651) 201-2762 FAX (651) 201-2763

APPLICATION AND DEADLINE

Complete the enclosed application and submit to the Board office, along with the application fee of \$160.00. **FEE IS NON-REFUNDABLE.**

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.

REGISTRATION FORM

Complete the enclosed license registration form and submit to the Board office.

SUPPORTING DOCUMENTATION (as stated in application)

Required supporting documentation will be accepted in the Board office independent of the application. Official transcripts must be received **directly** from your school or college of optometry.

NBEO EXAMINATION RESULTS

It is the applicant's responsibility to insure the results of Part I, Basic Science; Part II, Clinical Science; Part III, Patient Care and TMOD are received in the Board office directly for NBEO.

STATE LAW EXAMINATION

The state law examination will be based on the Minnesota Statutes and Board Rules for optometry. Applicants may choose to take the Minnesota Law Examination online through the National Board of Examiners in Optometry (NBEO) www.optometry.org or at the office of the Minnesota Board of Optometry by appointment. **This examination must be completed prior to the Board's review of your application.**

ISSUANCE OF MINNESOTA LICENSES TO PRACTICE OPTOMETRY

The Minnesota Board of Optometry will issue licenses within two weeks of receiving the application, fees and all appropriate documentation in the board office.

QUESTIONS?

Contact: Minnesota Board of Optometry
2829 University Avenue SE, Suite 403
Minneapolis, MN 55414-3250
(651) 201-2762 FAX (651) 201-2763
Website: www.optometryboard.state.mn.us
Email: optometry.board@state.mn.us

APPLICATION TO PRACTICE OPTOMETRY

STATE OF MINNESOTA
 Board of Optometry
 2829 University Avenue SE #403
 Minneapolis, MN 55414-3250
 (651) 201-2762

DATE OF APPLICATION: Day Month Year

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INSTRUCTIONS TO APPLICANT
<ol style="list-style-type: none"> 1. Answer all questions completely, accurately, and legibly or the application will be returned. 2. The name you enter must exactly match the name on the supporting documents, or documentation of formal name change must be submitted. 3. All addresses must include zip code if requested on the application. 4. Required fee of \$160.00 must accompany application. FEE IS NON-REFUNDABLE. 5. Failure to answer all questions completely and accurately, and/or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.

TO: The Minnesota Board of Optometry

I hereby make application for registration to practice optometry in the State of Minnesota and submit the following statement concerning my birth, preliminary and optometry education and practice.

YOUR CURRENT NAME AND ADDRESS			
FULL LEGAL NAME (LAST, FIRST, MIDDLE)			
STREET ADDRESS			
CITY	STATE OR PROVINCE	ZIP CODE	COUNTY
HOME PHONE	OTHER PHONE/CELL	GENDER	MAIDEN NAME
SOCIAL SECURITY OR ALEIN REGISTRATION NUMBER		OE TRACKER NUMBER	
EMAIL ADDRESS			

BASIS FOR APPLICATION *

Nationally Administered Examination _____

*Successful completion of the NBEO Part I, Part II, Part III and TMOD are required.

*******FOR BOARD USE ONLY*******

APPLICATION #	CHECK/RECEIPT #	BOARD ACTION
LICENSE #	AMOUNT PAID	BOARD DATE

RECORD OF BIRTH			
DATE OF BIRTH	CITY OF BIRTH	COUNTY OF BIRTH	STATE/PROVINCE OF BIRTH

PRELIMINARY EDUCATION				
NAME OF HIGH SCHOOL	CITY	STATE/PROVINCE	FROM DATE	TO DATE
NAME OF COLLEGE	CITY	STATE/PROVINCE	FROM DATE	TO DATE
NAME OF COLLEGE	CITY	STATE/PROVINCE	FROM DATE	TO DATE
NAME OF COLLEGE	CITY	STATE/PROVINCE	FROM DATE	TO DATE
TYPE OF DEGREE RECEIVED	NAME OF ISSUING SCHOOL		DATE DEGREE RECEIVED	
TYPE OF DEGREE RECEIVED	NAME OF ISSUING SCHOOL		DATE DEGREE RECEIVED	

OPTOMETRIC EDUCATION (OPTOMETRY SCHOOL MUST BE APPROVED BY BOARD)			
NAME OF SCHOOL	CITY	STATE/PROVINCE	GRADUATION DATE

PRACTICAL EXPERIENCE			
NAME OF FACILITY	LOCATION	FROM DATE	TO DATE
NAME OF FACILITY	LOCATION	FROM DATE	TO DATE
NAME OF FACILITY	LOCATION	FROM DATE	TO DATE

STATES/PROVINCES TO WHICH YOU HAVE MADE APPLICATION

STATE/PROVINCE	DATE OF APPLICATION	BASIS FOR APPLICATION	
		<u>Examination</u>	<u>Endorsement</u>

STATES/PROVINCES IN WHICH YOU ARE OR HAVE BEEN REGISTERED OR LICENSED

You must have each state complete a license verification form.

STATE/PROVINCE	LICENSE NUMBER	DATE ISSUED	EXPIRATION	HOW OBTAINED	
				<u>Examination</u>	<u>Endorsement</u>

MEMBERSHIP IN PROFESSIONAL SOCIETIES AND ORGANIZATIONS

NAME OF ORGANIZATION	FROM DATE	TO DATE

DOCUMENTATION TO BE SUBMITTED

- _____ Certified transcripts of non-optometric college education.
- _____ Certified transcript of optometric education (must show degree conferred).
- _____ Two (2) letters attesting to the moral and ethical character of the applicant.
One letter is to be from a practicing optometrist in good standing who has personal knowledge of applicant.
- _____ Certified copy of NBEO examination results
 - _____ Part I, Basic Science
 - _____ Part II, Clinical Science
 - _____ Part III, Patient Care
 - _____ TMOD

IN ANSWERING THE FOLLOWING QUESTIONS, PLEASE CHECK THE APPROPRIATE ANSWER NEXT TO EACH QUESTION. IF NECESSARY, ATTACH ADDITIONAL SHEETS TO PROVIDE SUFFICIENT DETAIL. YOU MUST ANSWER ALL QUESTIONS WITH “YES” OR “NO”.

YES NO

		Are you presently in good physical and mental health? If not, give particulars.
		Have you ever been voluntarily or involuntarily committed to a public or private mental health facility, detoxification center, or chemical dependency treatment facility, or been disabled by accident or physical or mental illness? If so, give particulars and provide medical records.
		Do you now, or have you ever, personally used or administered to yourself any controlled substances, or have you ever been treated for drug or alcohol abuse? If so, give particulars as well as the attending physician’s statement.
		Have you ever been the subject of an investigation by any Federal, State, or Local agency laws or regulations? If so, give particulars.
		Have you ever been denied a license or certificate of registration by, or the privilege of taking an examination before any State Examining Board, or has a conditioned license or certificate of registration ever been issued to you by any state examining board? If so, give particulars.
		Has your license or certificate of registration to practice optometry in any state or country ever been voluntarily or involuntarily (i.e. by Licensing Board Order or any other form of disciplinary action) revoked, suspended, restricted, or conditioned by a Licensing Board? If so, give particulars.
		Have you ever been notified of any investigations by any state examining board, of any complaints against you relative to the practice of optometry, or have you ever been reprimanded or censured by any licensing board? If so, give particulars.
		Have you ever been a defendant in any malpractice lawsuits, had any malpractice settlement, or have any pending? If so, give particulars.
		<p>I validate that by affirming “YES” that:</p> <ol style="list-style-type: none"> 1. I am a graduate of an approved college of optometry after May 1, 1993 and; 2. I have completed a course certification of 100 hours of approved study in the use of legend drugs or my accredited college of optometry has certified through NBEO that this education was included in my optometric curriculum and; 3. I will request validation of the TMOD examination scores to be sent directly to the board.

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: _____

_____ being first duly sworn, says that s/he is the person referred to in the above application for registration to practice optometry in the State of Minnesota, and that the statements herein contained are each and all strictly true in every respect.

Signature of Applicant

Sworn to before me this _____ day of _____, _____.

Signature of Notary

My Commission Expires: _____

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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.

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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