Reset Form

# APPLICATION FOR OPTOMETRY LICENSE

State Form 7 (R16 / 9-17)
Approved by State Board of Accounts, 2017

**INDIANA OPTOMETRY BOARD**
**PROFESSIONAL LICENSING AGENCY**
402 West Washington Street, Room W072
Indianapolis, IN 46204
Telephone: (317) 234-8800
E-mail: pla14@pla.IN.gov
www.pla.IN.gov

*INSTRUCTIONS:*
1. *The fee for this application is $200.00, payable to the Indiana Professional Licensing Agency, in accordance with 852 IAC 1-10-1.*
2. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
3. *All fees are non-refundable and non-transferable.*
4. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

| | |
|---|---|
| **APPLICATION FEE** | |
| **DATE FEE PAID *(month, day, year)*** | |
| **RECEIPT NUMBER** | |
| **LICENSE NUMBER** | |
| **LICENSE ISSUANCE DATE *(month,day, year)*** | |

**APPLICANT**

*Attach one (1) passport-quality photograph taken not earlier than one (1) year prior to the date of application, dated and signed on the back. In the applicant's handwriting, put "I certify that this is a true photograph of me."*

**DO NOT WRITE ABOVE THIS LINE**

## APPLICANT INFORMATION

| | | |
|---|---|---|
| Name of applicant (*last, first, middle, maiden*) | | Social Security number* |
| Address (*number and street or rural route*) | | City |
| State | ZIP code | Telephone number (*daytime*) ( ) |
| E-mail address | Date of birth (*month, day, year*) | Place of birth (*city and state or country*) |

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)* ☐ Yes ☐ No

Are you an active duty member of the military? *(Optional)* ☐ Yes ☐ No

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select one of the following.)*
☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 U.S.C. § 1641).

Please check the box to be included on the Health Care Volunteer Registry established by IC 25-22.5-15. *(Optional)* ☐

## BASIS FOR LICENSURE

Application for licensure by: (*Please check appropriate box.*) ☐ EXAMINATION ☐ ENDORSEMENT

## OPTOMETRY SCHOOL OF GRADUATION

| Name of school | Location | Date of graduation |
|---|---|---|
| | | |

## EXAMINATION RECORD - NATIONAL BOARD OF EXAMINERS IN OPTOMETRY

| National Boards | Date of most recent test *(month, day, year)* | Where taken *(state)* | How many times? |
|---|---|---|---|
| **Part I** | | | |
| **Part II** | | | |
| **Part III** | | | |
| **TMOD** | | | |
| **ANY OTHER NBEO EXAMINATION TAKEN?** | | | |

## STATE BOARD EXAMINATION

If you are applying by endorsement and have not taken Part III of the National Board of Examiners in Optometry (NBEO), please list the State Board Examination you will be endorsing to the State of Indiana.

| State | Examination date *(month, day, year)* | License current? |
|---|---|---|
| | | ☐ Yes ☐ No |

| PRE-PROFESSIONAL EDUCATION | | | | |
|---|---|---|---|---|
| **Name of School** | **Location** | **From *(month, year)*** | **To *(month, year)*** | **Degree** |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| PROFESSIONAL EDUCATION (*SCHOOL OF OPTOMETRY*) | | | | |
|---|---|---|---|---|
| **Name of School** | **Location** | **From *(month, year)*** | **To *(month, year)*** | **Degree** |
| | | | | |
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| STATES OF LICENSURE | | | | |
|---|---|---|---|---|
| Original state of licensure | | | License number | |
| *List all states (including Indiana) in which you have been licensed or certified to practice optometry.* | | | | |
| **State** | **License Number** | **Date Issued *(month, day, year)*** | **Date Expires *(month, day, year)*** | **Issued by examination or endorsement** |
| | | | | |
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| WHERE YOU HAVE LIVED | |
|---|---|
| *List all the places you have lived since graduation from Optometry School.* | |
| **General Location** | **Dates *(month, day, year)*** |
| | |
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| | |

| WHERE YOU HAVE BEEN EMPLOYED | | |
|---|---|---|
| *List all the places you have been employed since graduation from Optometry School.* | | |
| **Name and Address of Employer** | **Responsibilities** | **Dates *(month, day, year)*** |
| | | |
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## STATEMENTS

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

1. Have you ever previously filed an application in the State of Indiana? ☐ Yes ☐ No

2. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held? ☐ Yes ☐ No

3. Have you ever been denied a license, certificate, registration or permit to practice optometry or any regulated health occupation in any state (*including Indiana*) or country? ☐ Yes ☐ No

4. *Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,*
   (1) have you ever been arrested; ☐ Yes ☐ No
   (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (3) have you ever been convicted of any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or ☐ Yes ☐ No
   (5) have you ever pled *nolo contendre* to any offense, misdemeanor, or felony in any state? ☐ Yes ☐ No

5. Do you have any condition or impairment (including a history of alcohol or substance abuse) that currently interferes, or if left untreated may interfere, with your ability to practice in a competent and professional manner? ☐ Yes ☐ No

6. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No

## APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

| Signature of applicant | Date signed (*month, day, year*) |
|---|---|
| | |

## AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Indiana Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency, or any of its authorized representatives in connection with processing any application for optometry licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Indiana Professional Licensing Agency to disclose to the aforementioned organizations, persons and institutions any information which is material to my application, and I hereby specifically release the Agency and Board from any and all liability in connection with such disclosure.

A photostatic copy of the authorization has the same force and effect as the original.

## AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

| Signature of applicant | Date signed (*month, day, year*) |
|---|---|
| | |

# VERIFICATION OF OPTOMETRIST STATE LICENSURE

Part of State Form 7 (R16 / 9-17)

Approved by State Board of Accounts, 2017

Please return to:
**INDIANA OPTOMETRY BOARD**
**PROFESSIONAL LICENSING AGENCY**
402 West Washington Street, Room W072
Indianapolis, IN 46204
Telephone: (317) 234-8800
E-mail: pla14@pla.IN.gov
www.pla.IN.gov

***INSTRUCTIONS:***

1. *Complete this form.*
2. *Make copies to send to each state in which you hold or have held a license.*
3. *Request the state(s) to complete and send directly to the address on the upper right.*
4. *If you are applying for licensure by endorsement based upon a state constructed examination, the state board must complete the "Endorsement Criteria" section on the back of the verification form.*

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

***PLEASE TYPE OR PRINT AND ANSWER ALL QUESTIONS.***

| APPLICANT INFORMATION | | |
|---|---|---|
| Name of applicant (*last, first, middle, maiden*) | | Social Security number* |
| Address (*number and street or rural route*) | | |
| City | State | ZIP code |
| Date of birth (*month, day, year*) | License number | Date of issue (*month, day, year*) |
| I hereby authorize the state of _____ to furnish the Indiana Professional Licensing Agency with the information below. | | |
| Signature of applicant | | Date signed (*month, day, year*) |

| LICENSE INFORMATION | | |
|---|---|---|
| License number | Date of issue (*month, day, year*) | Date of expiration (*month, day, year*) |
| Has the license been subject to disciplinary action? ☐ Yes ☐ No<br>(*If yes, please attach copies of any disciplinary action taken by your board.*) | | |

| LICENSED BY | | |
|---|---|---|
| ☐ Examination | ☐ Endorsement | ☐ Other |
| Licensed by National Board of Examiners in Optometry:<br>☐ Part I ☐ Part II ☐ Part III ☐ TMOD | | |
| State Constructed Examination administered?<br>☐ Yes ☐ No | Date of examination (*month, day, year*) | |

| | |
|---|---|
| Name | Please Affix Board Seal |
| Title | |
| State Board | |
| Date (*month, day, year*) | |

## ENDORSEMENT CRITERIA

If you are applying for an optometry license based upon a state constructed examination, the state board must complete this section of the form. In order to qualify for an Indiana license, the applicant must have attained an average score of 75, with no score below 65, on a **hands-on clinical** skills examination equivalent to Indiana examination. In order to assist the board with its evaluation, please indicate whether the applicant was required to pass a hands-on clinical test in the following areas and the applicant's score on each test.

NOTE: This information is not required if the applicant has passed Part III of the NBEO examination.

| | |
|---|---|
| 1. Determining refractive status (*e.g. retinoscopy, subjective refraction*) | Score _____ ☐ Hands-on |
| 2. Contact lens fitting (*e.g. insertion, removal, fit evaluation*) | Score _____ ☐ Hands-on |
| 3. Internal eye health evaluation other than direct ophthalmoscopy (*e.g. monocular indirect, binocular indirect, gonioscopy, contact or non-contact fundus lens*) | Score _____ ☐ Hands-on |
| 4. Neurological evaluation (*e.g. fields, pupils, Amsler grid, confrontation*) | Score _____ ☐ Hands-on |
| 5. External eye health (*e.g. slit lamp, ocular motility, foreign body removal*) | Score _____ ☐ Hands-on |
| 6. Binocular function (*e.g. cover test, Worth Four-Dot, Bagolini lenses, Keystone skills*) | Score _____ ☐ Hands-on |
| 7. Case history | Score _____ ☐ Hands-on |
| 8. Ophthalmic materials (*e.g. lens designs, verification, adjustment*) | Score _____ ☐ Hands-on |
| 9. Tonometry | Score _____ ☐ Hands-on |
| 10. Low vision | Score _____ ☐ Hands-on |