Reset Form

# APPLICATION FOR OPTOMETRIC LEGEND DRUG CERTIFICATE

State Form 45276 (R10 / 3-21)


**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 $20.00, 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.*
5. *Please complete the following information and supply supporting documentation to begin the certificate process.*

* 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.

**FOR OFFICE USE ONLY**

| Application fee | Date fee receipted (*month, day, year*) | Receipt number |
|---|---|---|
| Certificate number | Date issued (*month, day, year*) | |

**DO NOT WRITE ABOVE THIS LINE**

**NOTICE:** Under IC 25-24-3-17(a), any licensed optometrist who administers therapeutic legend drugs, dispenses legend drugs, prescribes legend drugs, or dispenses or prescribes diagnostic legend drugs must be certified by the Indiana Board of Pharmacy.

| | |
|---|---|
| Name of applicant (*last, first, middle*) | |
| Business name of applicant *(if applicable)* | |
| Social Security number * | Date of birth (*month, day, year*) |
| Address of applicant (*number and street or rural route*) | City, state, and ZIP code |
| Telephone number (*daytime*)<br>(  ) | E-mail address |
| Indiana Optometry license number | |

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select ONLY ONE of the following.)*
☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 USC § 1641). ☐ I am authorized by the Federal government to work in the United States.

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

Has any previous license or certificate held by the applicant been surrendered, revoked, denied, or is pending action?
☐ Yes ☐ No

*If Yes, please provide details.*

*To become certified, you must complete the following and provide documentation:*

1. Provide proof of education in ocular pharmacology from a school or college of optometry or medicine approved by the Indiana Optometry Board by providing a transcript of your course work from the institution; and,
2. Provide a photocopy of either a score report or a certificate proving successful completion of the Treatment and Management of Ocular Disease (TMOD) examination that is administered by the National Board of Examiners in Optometry.

**APPLICATION AFFIRMATION**

I hereby I affirm, under penalties for perjury, that the statements made in this application are true, complete, and correct.
A photostatic copy of this authorization has the same force and effect as the original.

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