

**Government Of The District Of Columbia
 Department Of Health – Health Regulation & Licensing Administration
 New License Application
 Board of Optometry**

Please read the application instructions before completing this form. If you have any questions, please call HRLA's toll-free Customer Service line at 1-877-672-2174 Monday through Friday 8:30AM to 4:30PM EST. A charge of \$65 will be imposed for dishonored checks (Public Law 89-208).

Section 1: Requested License Type (Application fee is NON-REFUNDABLE)

Please check the appropriate License Type with fee:

- OP – Optometrist by Examination \$433.00
(Includes TPA & DPA Authorities)
- OP – Optometrist by Endorsement \$433.00
(Includes TPA & DPA Authorities)
- Existing DC Licensed Optometrist – \$230.00
Adding DPA Authority: License # OP _____
- Existing DC Licensed Optometrist – \$230.00
Adding TPA Authority: License # OP _____
(This authority automatically receives DPA authority)
- Duplicate License (limit 5) ____ x \$34.00 = \$ _____ .00
- Total Enclosed** **\$ _____ .00**

CRIMINAL BACKGROUND CHECK: All EXAMINATION and ENDORSEMENT applicants are required to undergo a Criminal Background Check. To schedule an appointment, please call 1-877-783-4187 or visit www.identogo.com.

\$85 Application fee + 348 License Fee = \$433
 \$85 Application fee + \$145 License fee = \$230

Please make check or money order payable to **DC Treasurer**.

Mail Application and Fee to:

**D.C. Board of Optometry
 P.O. Box 37802
 Washington, DC 20013**

Section 2: Applicant Name and Demographic Information – PLEASE PRINT

Enter your name **EXACTLY** as it should appear on your license. If your name has changed at any point, please complete Section 3 on page 2. You must provide a copy of legal name change documents for **EACH** time your name changed (if applicable).

 FIRST NAME MI LAST NAME SUFFIX

_____ SOCIAL SECURITY NUMBER If you do not provide a social security number, a sworn affidavit is required.	_____ DATE OF BIRTH
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_____ PLACE OF BIRTH Please provide the City and State for US birthplace or Country for foreign place of birth.	GENDER Please check the correct box. Female <input type="checkbox"/> Male <input type="checkbox"/>	OE TRACKER NUMBER _____
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Section 4B: Business Address – PLEASE PRINT

PLEASE NOTE: This information will be made available to the public.

Even if you have a P.O. Box, a street address should be provided.

BUSINESS STREET ADDRESS 1

BUSINESS ADDRESS CONT.

CITY STATE ZIP CODE

BUSINESS PHONE NUMBER FAX NUMBER EMAIL ADDRESS

PLEASE NOTE: Each licensee, registrant, or person certified shall notify the Board in writing of any change of address of place of residence or place of business or employment within 30 days after the change of address.

Section 4C: Preferred Mailing Address

Indicate your preferred mailing address. This will be the address where all licensing documents and all Board correspondence will be mailed.

Home Address Business Address

PLEASE NOTE: Each licensee, registrant, or person certified shall notify the Board in writing of any change of address of place of residence or place of business or employment within 30 days after the change of address.

Section 5: Colleges, Universities, and Professional Schools Attended – PLEASE PRINT

Please list all colleges, universities, and professional schools attended. Please start with the most recent.

School Name, City, State, Country	Hours Completed	Graduation Date	Type of Degree/Certificate

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Section 8: Screening Questions – Applicants MUST answer all questions.

Please answer all of the following questions by checking the appropriate box. **If you answer "YES" to any of the questions, you must provide an answer on a separate sheet of paper and attach to the application.**

A.	<p>Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement. Please read the information below carefully before responding "YES" or "No" to the question. Any false information provided requires the Department of Health to proceed immediately to revoke your license or permit for which you are applying and fine you one thousand dollars (\$1,000), pursuant to D.C. Official Code Section 476-2864 (2001).</p> <p>IF YOU ANSWERED "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR RENEWAL APPLICATION BE DENIED.</p> <p>As of this date, do you owe more than one hundred dollars (\$100.00) to the Government of the District of Columbia as a result of the following:</p> <ol style="list-style-type: none"> 1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985); 2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994); 3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1994); 4. Past due taxes; 5. Past due District of Columbia Water and Sewer Authority service fees; 6. Fines or penalties assessed to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication). <p>The information presented above complies with the requirement to submit with your application for licensure or permit under the Clean Hands Before Receiving a License or Permit Act of 1996.</p>	<p align="right">YES NO <input type="checkbox"/> <input type="checkbox"/></p>
B.	Have you ever been convicted or investigated of a crime or misdemeanor (other than traffic violations) not previously reported?	<p align="right">YES NO <input type="checkbox"/> <input type="checkbox"/></p>
C.	Have you ever been party to a malpractice action or had malpractice action brought against you?	<p align="right">YES NO <input type="checkbox"/> <input type="checkbox"/></p>
D.	Have you ever voluntarily surrendered a license after formal charges were filed against you or while under investigation?	<p align="right">YES NO <input type="checkbox"/> <input type="checkbox"/></p>
E.	Have you been terminated or forced to resign from a clinical or professional training program?	<p align="right">YES NO <input type="checkbox"/> <input type="checkbox"/></p>
F.	Do you have a physical or medical condition that could impair your ability to practice your profession?	<p align="right">YES NO <input type="checkbox"/> <input type="checkbox"/></p>
G.	Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?	<p align="right">YES NO <input type="checkbox"/> <input type="checkbox"/></p>
H.	<ol style="list-style-type: none"> 1. Have you withdrawn an application (in DC or any other state/jurisdiction) to your profession? 2. Has any authority or peer review board taken adverse action against your license or privileges? 3. Are you currently under investigation or were you investigated by any authority or peer review board for any violations of state, federal, or local laws? 4. Has any authority or peer review board informed you of any pending charge(s) or investigation previously reported to this Board? 	<p align="right">YES NO <input type="checkbox"/> <input type="checkbox"/></p>
I.	Have you ever been terminated or asked to resign from employment since obtaining your (professional) license?	<p align="right">YES NO <input type="checkbox"/> <input type="checkbox"/></p>

Section 9: License Application Attestation and Signature

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

APPLICANT SIGNATURE

NAME (Please Print)

DATE