COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF OPTOMETRY
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-7155

APPLICATION FOR A LICENSE TO PRACTICE OPTOMETRY BY RECIPROCITY - $25.00 FEE

YOU MAY NOT PRACTICE OPTOMETRY IN THE COMMONWEALTH OF PENNSYLVANIA UNTIL YOU HOLD A LICENSE

QUALIFICATIONS FOR LICENSE BY RECIPROCITY

1. Graduation from an American Optometric Association approved school of optometry.

2. Passing score on the National Board Examinations
   National Board Scores

   Part III = Clinical Skills/VRICS prior to 1993

   OR

   Part III/PC (3) after 1993 *(Clinical Skills)*

Contact National Board of Examiners in Optometry, 200 S. College Street, #1920, Charlotte, NC 28202, (800-969-3926) and request scores to be sent directly to the Pennsylvania Board.

ADDITIONAL DOCUMENTS NEEDED

1. **Statement, attested to by the Secretary or President of the Optometric Board in state of original licensure which avers that:**

(1) The applicant received a license to practice optometry by passing examinations in subjects stated in the act at the time the applicant was examined.

(2) The applicant practiced optometry for at least 4 years continuously in the state of licensure, immediately prior to applying for reciprocity in this Commonwealth.

(3) The board of original licensure recommends the applicant for licensure to the Board.

2. **Fee - $25.00** made payable to the **"Commonwealth of Pennsylvania"**. Fee is non-transferable and non-refundable. A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason.

3. If your name on any part of the application or any other document submitted in connection with the application is different than your present name, submit a copy of the document indicating the name change, such as a marriage certificate.

4. Effective May 15, 2010: You must send a recent Criminal History Records Check (CHRC) for every state in which you have lived in the last five years. **For Pennsylvania**, request it from the Pennsylvania State Police (PSP). Contact the PSP for instructions and fee at www.psp.state.pa.us . **For out-of-state applicants**, obtain a CHRC from the state where you are living. The CHRC must be obtained from a State Law Enforcement Authority but it does **not** have to be sent directly from them. The CHRC must be dated within six (6) months of the date the application is submitted. Other documentation may be required later after review.

5. Verification of Graduation from Optometry College - (Page 4 of the application.)

6. Contact the State Board Offices where you hold or ever held a license to practice and request Letters of Good Standing. The Letter must include the following: license issue and expiration date, license status (current or expired), and disciplinary standing. The Letters of Good Standing must be sent directly to the Pennsylvania Board from each State Board office in an official Board envelope.

NOTE: If the application process has not been completed within SIX months from the date it was SIGNED, applicants will be required to submit supporting documents, as necessary.

If the application process has not been completed within ONE YEAR from the date it was SIGNED, applicant will be required to submit another application, processing fee and supporting documents, as necessary.

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www.dos.state.pa.us/opt
st-optometry@pa.gov

APPLICATION FOR A LICENSE TO PRACTICE OPTOMETRY BY RECIPROCITY

Complete the entire application and submit all the additional documents. **TYPE OR PRINT**

License by Reciprocity – **Fee $25.00** - Indicate which state: _____

NAME: _____
Last First Middle Maiden

ADDRESS: _____
Street

_____
City State Zip

EMAIL ADDRESS:_____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

BUSINESS TELEPHONE #: (____)_____ HOME TELEPHONE #: (____)_____

NAME OF OPTOMETRY SCHOOL: _____

DATE OF GRADUATION: _____
Month Day Year

You must send a recent Criminal History Records Check (CHRC) for every state in which you have lived in the last five years. The report(s) must be dated within 6 months of the date of this application.

List all states here:_____

THE FOLLOWING QUESTIONS MUST BE ANSWERED:

Printed Name of Applicant: _____

1. Do you hold or have you held a professional license for any profession in this state or any other state or jurisdiction?

   If yes, please list below all professions and states where you have been licensed and request a letter of good standing be sent directly from each state board to the Pennsylvania Board. **( ) YES ( ) NO**

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2. Have you ever withdrawn an application for a license, had an application for a license denied or refused, or agreed not to reapply for a license in another state, territory or country? A license includes a registration or certification. **( ) YES ( ) NO**

3. Has any disciplinary action been taken against your license in another state, territory or country? **( ) YES ( ) NO**

4. Have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court. **( ) YES ( ) NO**

5. Are you, or have you ever been, addicted to the intemperate use of alcohol or the habitual use of narcotics or other habit-forming drugs? **( ) YES ( ) NO**

Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Impaired Professional Program.

IF YOU ANSWERED YES TO ANY QUESTIONS FROM 2 - 6, YOU MUST PROVIDE FULL DETAILS. INCLUDE COURTHOUSE CERTIFIED COPIES OF ALL DOCUMENTS.

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Printed Name of Applicant:

_____

CERTIFICATION OF REQUIRED INSURANCE/VERIFICATION

By my signature below, I verify that upon licensure, I will obtain and maintain the required minimum amount of professional liability insurance, commensurate with the level of practice I will be licensed for. NOTE: The insurance requirements for both "diagnostic pharmaceutical agents" and "therapeutic pharmaceutical agents" licenses are $200,000 per occurrence and $600,000 per annual aggregate. The minimum insurance requirement for individuals certified to treat glaucoma is $1,000,000 per occurrence and $3,000,000 per annual aggregate. I further verify that I will notify the Board within 30 days of my failure to be covered by the required amount of insurance.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 (relating to unsworn falsification to authorities) and may result in the suspension or revocation of my license. I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the penalties for tampering with public records or information pursuant to 18 Pa. C.S. Section 4911. (NOTARIZATION IS NOT REQUIRED.)

_____ _____

APPLICANT'S SIGNATURE DATE

Note that disclosing your social security number on this application is <u>mandatory</u> for the State Board of Optometry to comply with the requirements of the federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of PA at 23 Pa. C.S. section 4304.1(a). To enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is <u>mandatory</u> for this board to comply with the reporting requirements of the federal Healthcare Integrity and Protection Data Bank. Reports to the HIPDB must include the licensee's social security number.

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VERIFICATION OF GRADUATION FROM OPTOMETRY SCHOOL

To be completed by applicant:

NAME: _____
Last First Middle Maiden

ADDRESS: _____
Street

_____
City State Zip

NAME OF OPTOMETRY SCHOOL: _____

ADDRESS: _____
Street

_____
City State Zip Telephone Number

To be completed by the Dean or Registrar:

VERIFICATION OF GRADUATION

I certify that _____ has successfully
(Name of Applicant)

completed all the required courses and examinations and has graduated from the above named school

on this date: _____
Month Day Year

_____
Signature of Dean or Registrar

_____
Date

(SEAL OF SCHOOL)

UPON COMPLETION, SCHOOL MUST RETURN THIS FORM DIRECTLY TO THE PENNSYLVANIA BOARD OF OPTOMETRY. <u>DO NOT RETURN TO THE APPLICANT.</u>

Rev. 02/22/2013