TENNESSEE BOARD OF DISPENSING OPTICIANS
STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
665 Mainstream Drive
NASHVILLE, TENNESSEE 37243
LOCAL (615) 532-5080
TOLL FREE (800) 778-4123

APPLICATION FOR APPRENTICESHIP TRAINING IN OPHTHALMIC DISPENSING

INSTRUCTIONS

1. Complete this application, sign, and enclose a non-refundable check for One Hundred Ten Dollars ($110) payable to the Board of Dispensing Opticians, and mail it to the above address.
2. Attach a notarized photocopy of your birth certificate to the application.
3. Attach a "passport" size photograph taken within the preceding twelve (12) months to the front of the application.
4. Attach proof of graduation from high school or general equivalency diploma. (GED)
5. Allow fourteen (14) working days for information mailed to our Office to be received and placed in your file. Federal Express or special courier services will not reduce the processing time. Additionally, if Federal Express or special courier services are used, you will be responsible for charges incurred.
6. If you have been licensed, certified, registered, or permitted by any state to practice as a dispensing optician (or any other health care professional, you must request a verification from each and every state. The verification must be mailed directly to the Board's Administrative Office.
7. If the application is not complete upon receipt by the Board's Administrative Office, a deficiency letter will be sent to you by certified mail or by email. The supporting documentation requested in the letter must be received in the Board's Administrative Office within sixty (60) days from the date of the initial deficiency letter. **Files not completed within sixty 60) days will be closed**.
8. **IT'S THE LAW!** If you change your mailing address, you must notify the Board's Administrative Office, in **writing,** within thirty (30) days. Failure to abide by this law could affect your license, since failure to receive the renewal application does not relieve you of the responsibility for timely renewal.
9. **You must write your social security number on the application for it to be complete. State law requires social security numbers on this application. TCA § 36-5-1301(a), as authorized by 42 U.S.C. § 405(c)(2)(C)(i). The number will be used to verify your identity and for any other purpose allowed by state or federal law.**
10. All applicants must complete, sign and have notarized the Declaration of Citizenship form and submit the documents required by the Declaration of Citizenship form. The Declaration is available online at http://tn.gov/assets/entities/health/attachments/PH-4183.pdf

Attach a
Current Full
Faced Photograph

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1313-001 $100
1313-006 $ 10

APPLICATION FOR APPRENTICE DISPENSING OPTICIAN

PERSONAL INFORMATION

Name ____
Last **First** **Middle and/or Maiden**

Date of Birth ______________________ **Social Security Number** ______________________

Entitled to Live and Work in the U.S. Yes ___ No___ U.S. Citizen: Yes_____ No_____ All applicants must complete the Declaration of Citizenship form and have it notarized.

Current Home Mailing Address: **Current Practice Name & Address:***

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

***If you have no practice address, notify the Board of your practice address within 30 days of obtaining a practice address. If you have multiple practice address, please attach an additional page listing all practice addresses.**

Home Phone ______________________ **Work Phone** ______________________

E-Mail:____

Do you wish to receive notifications, including renewal notification, from Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. ____ **Yes** ____ **No**

Gender: Female _____ Male _____ **Race:** ______________________

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.) **Yes ____ No** _____

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.)

Yes ____ No _____

Have you ever been known by any other names besides what is listed above? **Yes ____ No** _____

If yes, please state in full every other name by which you have been known, the reason therefore, and inclusive dates so known:

____

____

Please complete your entire healthcare employment history, including work as a dispensing optician, starting

with the most current position first. Use the back of this page, if you need additional space. Dates of employment must be included.

Company/ Employer:	Address: (City, and State)	Position:	Duties:	Dates From: Mo./Yr.	To: Mo./Yr.

	YES	NO
Are you or have you ever been licensed in this profession in another state?	____	____
Are you or have you ever been licensed in any other profession in Tennessee or another state?	____	____

List below **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED**. Additional pages may be added if necessary. Request that verification of licensure be submitted directly to the Board's Office from each state.

STATE	PROFESSION	LICENSE NUMBER	CURRENT STATUS

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION. Additional information may be requested and/or required before a licensure decision may be made.

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:

a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;

b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical Condition"** includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.

3**."Minor Traffic Offense"** generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

5. **"Currently"** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

6. **"Illegal use of illicit or controlled substances"** means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.	**YES**	**NO**
1. Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice?	___	___
2. Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety?	___	___
If so, please list ______________________________		
(If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to be determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.)		
3. At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	___	___
4. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?	___	___
5. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism or other diagnosis of a predatory nature?	___	___
6. Have you ever held or applied for a license, privilege, registration or certificate to practice dispensing opticianry in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
7. Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	___	___
8. Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	___	___
9. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	___	___
10. Have you ever been rejected or censured by a Professional Association?	___	___
11. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered <u>against</u> you?	___	___
b. Have you ever had settlement of any legal action rendered <u>against</u> you?	___	___
c. Are there any legal actions pending <u>against</u> you or to which you are a party?	___	___
12. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
13. My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state)	___	___

AFFIDAVIT AND RELEASE

I, _______________________________________, of _________________________________, being duly sworn
(Applicant's Name) (City) (State)
and identified as the person referred to in this application, attest to the truth of each statement made in said application. I further attest that I have read and understand the law and the rules and regulations regarding the practice of my profession, which are posted on the Board's internet site and/or were provided to me by the Board office, and agree to abide by them in the practice of dispensing opticianry (apprentice) in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as an apprentice in dispensing opticianry.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications;

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character and other qualifications for certification.

ACKNOWLEDGE that I, as an applicant for certification, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_______________________________________ _______________________________________
SIGNATURE **DATE**

DIRECT SUPERVISOR FORM

THIS FORM MUST BE COMPLETED BY YOUR CURRENT SUPERVISOR

Per Rule 0480-1-.14(2)(a)-(b): Apprenticeship training must be supervised by a dispensing optician, optometrist, or ophthalmologist who has been licensed in Tennessee or another state for at least three (3) years and whose license to practice in Tennessee is current, undisciplined, unrestricted and unencumbered. (a) The supervisor shall work at the premises where the apprenticeship training is conducted. (b) The supervisor shall provide direct supervision at all times in accordance with T.C.A. § 63-14-103(a) and (f) and rule 0480-01-.01(8).

Full Name of Apprentice: ____

Name of Supervisor/TN License No.: ______________________________________

Licensed to Practice as: _______ Dispensing Optician _______Optometrist _______Ophthalmologist

Business Name/Name of Dispensary Where Training Will Occur:

____

Business Full Address: ____

____

____

Business Phone: ______________________________

Is the facility equipped with the recommended minimum equipment as stated in Rule 0480-1-.14(6)(c)(1) and (2)?
Yes ___ No ___

If not, how will apprentice achieve full training, including optical laboratory work?

____

____

Describe the type of facility where the apprentice will train: ____________________________

____

List the equipment the apprentice will train on: ______________________________________

____

List the duties the apprentice will be learning: ______________________________________

____

I request that ____ be registered under my supervision.
(Applicant)

____
Signature of Supervisor

Return this form to: BOARD OF DISPENSING OPTICIANS
665 Mainstream Drive
Nashville, TN 37243

ALTERNATE SUPERVISOR FORM

THIS FORM MUST BE COMPLETED BY YOUR ALTERNATE SUPERVISOR

Per Rule 0480-1-.14(5)(a)(1)-(2): A licensed dispensing optician may supervise no more than two (2) apprentices concurrently. (2) A licensed dispensing optician may provide supervision in the temporary and impermanent absence (a.k.a. alternate supervision) of the supervising licensee to one (1) of the two (2) apprentices being supervised concurrently.

Full Name of Apprentice: ____

Name of Alternate Supervisor/TN License No.: ____

Licensed to Practice as: _______ Dispensing Optician _______Optometrist _______Ophthalmologist

Business Name/Name of Dispensary Where Training Will Occur:

____

Business Full Address: ____

____

____

Business Phone: ______________________________

Is the facility equipped with the recommended minimum equipment as stated in Rule 0480-1-.14(6)(c)(1) and (2)?
Yes ___ No ___

If not, how will apprentice achieve full training, including optical laboratory work?

____

____

Describe the type of facility where the apprentice will train: ______________________________

____

____

List the equipment the apprentice will train on: ______________________________

____

List the duties the apprentice will be learning: ______________________________

____

I request that ______________________________ be registered under my supervision.
(Applicant)

____
Signature of Alternate Supervisor

Return this form to: BOARD OF DISPENSING OPTICIANS
665 Mainstream Drive
Nashville, TN 37243

APPRENTICESHIP TRAINING IN OPHTHALMIC DISPENSING
SEMI-ANNUAL EVALUATION FORM

Length of Training Program – Pursuant to T.C.A. §63-14-103(a)(10): The period of apprenticeship training must be a minimum of three (3) Years and must include a total of five thousand two hundred fifty (5,250) hours of full time or part time education and training under qualified supervision.

Semi-annual evaluation periods begin six (6) months from the initial registration and six (6) months thereafter until completion of the required training period. Make as many copies of this form as necessary.

The filing of these forms is **mandatory**. You will not receive reminders to submit this information. This is your responsibility. If these forms are not filed semi-annually, you will be considered not actively pursuing licensure and your application will be closed and you will be required to reapply and pay all fees.

Once you have completed a total of 5,250 hours of education and training under qualified supervision, you will be sent a letter, an application, instructions for completing a criminal background check, and a copy of the rules and regulations stating that you may apply for licensure. If, for any reason, you are not able to apply for licensure at that time, you are still considered to be in apprenticeship training and semi-annual evaluations forms must continue to be submitted to this office. Failure to do so will result in your apprenticeship file being closed. You will be required to complete a new apprenticeship application, pay the fee, and begin a new period of 3 year apprenticeship training.

Please remember, your apprenticeship date begins the date you receive confirmation from the Board. All 6 month evaluations must reflect these dates. If there is a break, a letter must be issued to the Board stating the reason for the break.

Mail to: BOARD OF DISPENSING OPTICIANS
665 Mainstream Drive
Nashville, TN 37243

Apprentice Name: ______________________________

Mailing Address: ______________________________

Home Phone: ____________________ Office Phone: ____________________

Current Practice Name & Address: ______________________________

____

Hours worked per week ________ **Total cumulative hours** earned since **beginning** apprenticeship: ____________________

Duties listed below should be given percentages of time performed on each during a normal work week. Total percentage must account for 100% of work time. Fill in each line.

% OF TIME	DUTIES PERFORMED
	Fitting and adjusting lenses to human faces
	Fitting contact lenses
	Interpreting prescriptions and making optical calculations
	Verifying
	Optical laboratory work
	Selling merchandise (Other than ophthalmic materials)
	Stock work
	Office work
	Describe other duties not listed

Direct/Alternate Supervisor's Signature/Title: ______________________________ Date: __________

This **current** evaluation period **began**: ____________________ and **ended** on ____________________

AFFIDAVIT OF APPLICANT

I declare and affirm that the statements made on this form are true, complete and correct. I understand that any false or misleading information on this form may be cause for denial or loss of my apprenticeship.

Signature of Applicant______________________________

Sworn to and subscribed before me this _____ day of _________, 20___.

Notary Public______________________________

Commission Expires______________________________ (Notary Seal)