HEALTH RELATED BOARDS REINSTATEMENT APPLICATION
TENNESSEE BOARD OF DISPENSING OPTICIANS

Mail to: Tennessee Department of Health
Health Related Boards
665 Mainstream Dr
Nashville TN 37243

License No. _____

Profession _____

Legal Name _____

Current Address _____ State _____ Zip _____

Phone Number ( ) _____

Name when Originally Licensed _____

Date License Last Renewed _____

Employment during last five (5) years:

Name of Employer	Complete Address of Employer	Position Held	Beginning Employment Date	Ending Employment Date

Reason(s) for Reinstatement _____

_____

1. Have you been convicted of any crime and not notified the Board? Yes _____ No _____
2. Has any health professional license you hold ever been disciplined? Yes _____ No _____
3. Are you currently in good physical and mental health? Yes _____ No _____

PLEASE RETURN LAST RENEWAL CERTIFICATE (wallet-size card) I

REQUIREMENTS FOR REINSTATEMENT: The renewal, retirement, and reinstatement of licenses is governed by the Tennessee Board of Dispensing Opticians' practice act (Tenn. Code Ann. § 63-14-101 et seq.) and rules (Tenn. Comp. R. & Regs. 0480-1)

Reinstatement of an expired license (Tenn. Comp. R. & Regs. 0480-1-.09(2)):

- Payment of all past due renewal and state regulatory fees.
- Payment of the renewal late fee.
- Submission of continuing education documentation equal to the hours required had the license remained in an active status. The continuing education must have been successfully completed within six (6) months immediately preceding the date of reinstatement.
- An applicant whose license has expired for a period of three years or more must apply, take and pass the examinations as required by the Board pursuant to Tenn. Comp. R. & Regs. 0480-1-.08, and pay the examination fee provided in Tenn. Comp. R. & Regs. 0480-1-.06 prior to being considered for reinstatement.

Reinstatement of a retired license (Tenn. Comp. R. & Regs. 0480-1-.11(3)):

- Payment of the current licensure renewal fee and state regulatory fee.
- If the license was in retirement and reinstatement is requested prior to the expiration of one year from the date of retirement, payment of the late renewal fee, past due renewal fees, and state regulatory fees.
- Submission of continuing education documentation for a calendar year. The continuing education must have been successfully completed within six (6) months of the requested date of reinstatement.
- An applicant whose license has been retired for a period of three years or more must apply, take and pass the examinations as required by the Board pursuant to Tenn. Comp. R. & Regs. 0480-1-.08, and pay the examination fee provided in Tenn. Comp. R. & Regs. 0480-1-.06 prior to being considered for reinstatement.

AFFIDAVIT

State of _____

County of _____

_____ personally appearing before me, and being duly sworn, says that the information given in this application is true and that ____ has read and understands this affidavit.

Legal Signature of Applicant _____

Sworn to before me this_____day of_____,_____.

Notary Public _____

Commission Expires _____

Seal

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DR
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF DISPENSING OPTICIANS
EMPLOYMENT VERIFICATION

Please complete Section 1 of this form. Have your employer complete Sections 2 and 3, then sign and notarize Section 4. Please return to the Division of Health Related Boards with the Reinstatement Application

SECTION 1

Name _____

Address _____

City_____State _____ Zip Code_____Phone # ( ) _____

SECTION 2

The above employee has applied for the renewal and reinstatement of his/her license. The Division of Health Related Boards needs the following information before the application can be processed.

Business/Facility Name _____

Address _____

City_____State_____Zip Code_____Phone # ( ) _____

Employer Name _____

Is the employer licensed as an Optometrist or Ophthalmologist? Yes _____ No _____

If Yes: State of licensure _____ License number _____

Name of Administrator/Employer completing Sections 2 & 3 _____

SECTION 3

Please list the dates of employment for the above employee:

Beginning Date _____

Ending Date _____

Please indicate if there has been any leave/break in service (sick, personal, etc.)

Beginning Date _____

Ending Date _____

Reason: _____

_____

_____

Was the above employee employed by your business/facility during the period of time in which his/her license was in expired or retired status?

Yes _____ No _____

If Yes, did the work duties/job responsibilities of the above employee change while his/her license was in expired or retired status?

Yes _____ No _____

If No, was the above employee employed by your business/facility as a Dispensing Optician during the period of time in which his/her license was in expired or retired status?

Yes _____ No _____

If Yes, was the above employee identified to the public as a Dispensing Optician (through verbal representation, advertisement, name tag, business card, etc.) during the period of time in which his/her license was in expired or retired status?

Yes _____ No _____

AFFIDAVIT

State of _____

County of _____

_____personally appearing before me, and being duly sworn, says that

_____is the employer referred to in the foregoing application, that the statements therein contained are true and that_____has read and understands this affidavit.

Employer Legal Signature _____

Sworn to before me this_____day of_____,_____.

Notary Public _____

Commission Expires _____

Seal

JB/G4085319/DPO

TENNESSEE DEPARTMENT OF HEALTH

MANDATORY PRACTITIONER PROFILE QUESTIONNAIRE FOR LICENSED HEALTH CARE PROVIDERS

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. §§ 63-51-101, et seq., requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health, and is requested in this questionnaire. From the information submitted, the Department compiles practitioner profiles which the law requires to be made available to the public via the World Wide Web and our toll-free telephone line. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information may result in a delay or denial of your licensure application and/or may result in disciplinary action against your license. The professions required to submit a profile questionnaire are:

Advanced Practice Nurses
Alcohol and Drug Counselors
Audiologists
Chiropractic Physicians
Clinical Pastoral Therapists
Dentists
Dietitian/Nutritionists
Dispensing Opticians
Electrologists
Licensed Registered Respiratory Therapists
Licensed Certified Respiratory Therapists
Licensed Laboratory Personnel
Marital & Family Therapists
Massage Therapists
Medical Doctors
Nursing Home Administrators
Occupational Therapists
Optometrists
Orthopedic Physician Assistants
Osteopathic Physicians
Pharmacists
Physician Assistants
Physical Therapists
Podiatrists
Professional Counselors
Psychologists
Respiratory Care Assistants
Social Workers
Speech Language Pathologists
Veterinarians

A blank copy of the profile questionnaire may be obtained from the following web site address: http://health.state.tn.us/Downloads/g6019027.pdf.

INSTRUCTIONS

QUESTIONNAIRE DEADLINE The provider must complete and submit the questionnaire before a license will be granted. Providers who have completed a similar questionnaire for another state's licensing board are, nevertheless, required to complete and submit this form. Changes to the questionnaire must be submitted within 30 days of the change.

COMPLETING THE QUESTIONNAIRE Complete the questionnaire by typing the information or by printing neatly in block letters in ball point pen. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.** If you need further instruction, contact your profession's licensing board by calling (615) 532-3202 or by calling toll free at (800) 778-4123.

SUBMITTING THE QUESTIONNAIRE Mail the completed profile questionnaire to:

Tennessee Board of *(board for your profession)*
Healthcare Provider Information 665
Mainstream Drive
Nashville, TN 37243

- **Do not return pages 1 through 4 with the questionnaire to the department.**
- **Keep a copy of the questionnaire for your records.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete Part I, noting the following:

- License number: Fill in your Tennessee license number and indicate your profession in the space provided. **If you have not been issued a license number, please leave this blank.**
- Social security number: Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.
- Primary Practice Address: Complete the practice address (if applicable). If your practice address is also your home address, you should know the Department is prohibited from placing your home address on the Internet without your request to do so. There is a box to check in Part I to request this. Retirees: Write in "N/A" for practice address. If you do not have a practice address at the time of completing this questionnaire, you must report your practice address within 30 days of obtaining a practice address.
- Supervising Physician: Physician assistants and advanced practice nurses must list all supervising physicians. In addition, advanced practice nurses must also complete the Notice and Formulary if you are prescribing. The Notice and Formulary is available online at http://health.state.tn.us/boards/Nursing/applications.htm.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a "yes" or "no" response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

A. List all hospitals at which you hold staff privileges. The definition for "hospital" can be found at T.C.A. § 68-11-201.

VI. MANAGED CARE AND TENNCARE PLANS

A. In the spaces provided, answer information about the Managed Care plans in which you participate and accept as a provider, if any. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

B. In the spaces provided, answer information about the TennCare plans in which you participate and accept as a provider, if any. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

VII. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal's period expired, or that the applicable board issued an agreed order or consent decree.

In the "Description of Violation" spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the "Description of Action" spaces, indicate the type of disciplinary action imposed against your professional license such as censure, reprimand, probation, etc.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer "yes" to any of the questions regarding Final Disciplinary Actions and/or Criminal Offenses and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions B and C in Part VII in their entirety before answering those questions.

VIII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

IX. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19, 1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE FOLLOWING AMOUNTS ARE NOT REQUIRED TO BE SUBMITTED.

A) For Medical Doctors and Osteopathic Physicians, judgments or settlements below $75,000 are not required to be submitted.
B) For Chiropractors, judgments or settlements below $50,000 are not required to be submitted.
C) For Dentists, judgments or settlements below $25,000 are not required to be submitted.
D) For all other professions, judgments or settlements below $10,000 are not required to be submitted. Pending malpractice claims are not required to be reported unless/until final adjudication against you.

X. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Practitioner's Name _ **License #** _____

Profession _____

TENNESSEE BOARD OF *(board for your profession)*
HEALTHCARE PROVIDER INFORMATION
TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

I. PRACTITIONER DATA

A. PROFESSION:_____ LICENSE NUMBER: _____

B. SOCIAL SECURITY NUMBER:_____ **(This will not be published)**.

C. NAME (INCLUDE MAIDEN, AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):

CURRENT NAME:

_____ _____ _____
(LAST) (FIRST) (MIDDLE AND MAIDEN NAME) (IF APPLICABLE)

FORMER NAME(S):

_____ _____ _____
(LAST) (FIRST) (MIDDLE)

_____ _____ _____
(LAST) (FIRST) (MIDDLE)

D. PRIMARY PRACTICE ADDRESS (attach additional sheets if necessary):

_____
(PRACTICE NAME)

_____
(STREET NUMBER AND NAME)

_____
(CITY) (STATE) (ZIP CODE)

☐ Check here if your primary practice address is your home address and you want it to be published as part of the profile and on the web site.

E. E-MAIL ADDRESS: _____ ☐
Your e-mail address will be published unless you elect not to by checking here.

F. WEB PAGE ADDRESS: _____ ☐
Your web page address will be published unless you elect not to by checking here.

G. PRACTICE TELEPHONE: (_____) _____ ☐
Your telephone number will be published unless you elect not to by checking here.

H. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.

1._____ 2. _____

I. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or advanced practice nurse) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:

1. _____

2. _____

Practitioner's Name _ **License #** _____

Profession _____

II. GRADUATE/ POSTGRADUATE MEDICAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/COUNTRY	DATE OF GRADUATION MM/DD/YYYY	TYPE OF DEGREE
1.			
2.			
3.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE,COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			

III. SPECIALTY BOARD CERTIFICATIONS:

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) YES ❑ NO ❑

(Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

Practitioner's Name _ **License #** _____

Profession _____

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❑ NO ❑

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❑ NO ❑

If "YES", list the title of the appointment, name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(9)) YES ❑ NO ❑

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

NAME OF HOSPITAL	CITY/STATE
1.	
2.	
3.	
4.	
5.	

VI. MANAGED CARE PLANS

A. Do you participate in any managed care plans? (Authority: T.C.A. §63-51-105(a)(15)) YES ❑ NO ❑

If "YES", list each: (Attach additional sheets, clearly labeled with this question number, if necessary)

NAME OF MANAGED CARE PLAN
1.
2.
3.
4.
5.

Practitioner's Name _ **License #** _____

Profession _____

B. Do you currently participate in and accept any TennCare plan(s) as a provider? YES ❑ NO ❑

If "YES", list each plan in which you currently participate or accept as a provider: (Authority: T.C.A. § 63-51-105(a)(16))

NAME OF TENNCARE PLAN
1. _____
2. _____
3. _____
4. _____
5. _____

VII. FINAL DISCIPLINARY ACTION (See Instructions):

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES ❑ NO ❑

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

	AGENCY NAME/ADDRESS	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

Practitioner's Name _ **License #** _____

Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted or reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-51-105(a)(4)) YES ❑ NO ❑

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME/ADDRESS	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.	_____	_____	_____	_____
	_____		_____	_____
	_____		_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

2.	_____	_____	_____	_____
	_____		_____	_____
	_____		_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by <u>any</u> hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A.: § 63-51-105(a)(4))

YES ❑ NO ❑

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME/ADDRESS	DATE	DESCRIPTION OF ACTION
1.	_____	_____	_____
	_____		_____
	_____		_____

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

2.	_____	_____	_____
	_____		_____
	_____		_____

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

Practitioner's Name _ **License #** _____

Profession _____

VIII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-51-105(a)(1)) YES ❑ NO ❑

If "YES" briefly describe the offense(s):

	DESCRIPTION OF OFFENSE(S)	DATE	JURISDICTION
1.	_____	_____	_____

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

2.	_____	_____	_____

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

3.	_____	_____	_____

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

IX. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. § 63-51-105(a)(5)) YES ❑ NO ❑

If "YES", indicate a brief description of the nature(s) of the claim, the date(s) of the claim report(s), and the amount of the judgment(s), award or settlement(s):

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.	_____	
2.	_____	_____
3.	_____	_____
4.	_____	_____

Practitioner's Name _ **License #** _____

Profession _____

X. OPTIONAL INFORMATION:

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-51-105(a)(11))

	TITLE	PUBLICATION	DATE
1.			
2.			
3.			
4.			

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-51-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION
1.		
2.		
3.		
4.		

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. §§ 63-51-113 and/or 63-51-118.

_____ Date:_____

(Signature of Provider)

REMINDER: Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law.