Optometrist License Application Packet

Contents:

Important Social Security Number Information:

If you have a Social Security Number, the law requires you to disclose it on your application for a professional or occupational license. 42 U.S.C. § 666(a)(13); RCW 26.23.150. It will be used under the state's child support enforcement program to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. If you do not have a Social Security Number, you are still eligible to apply for and obtain a credential if you meet the requirements. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you have questions.

In order to process your request:

Mail your application with Initial documentation and your check or money order payable to:

Department of Health
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Optometry Credentialing
P.O. Box 47877
Olympia, WA 98504-7877

Contact us:

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

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Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly. It is your responsibility to submit the correct forms required.

☐ **Application Fee**. This fee is non-refundable. You can check the online **fee page** for current fees.

☐ **Select if the following applies:**
Spouse or Registered Domestic Partner of Military Personnel

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you do not have one.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Address: List the address we should use to send any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See **WAC 246-12-310**.

Phone, Fax, and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

2. Personal Data Questions:

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession. If you answer "yes" to any questions in this section, you must provide an appropriate explanation.

You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Other License, Certification, or Registration:**
List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space. You must also print the **Verification Form** and provide it to each state or jurisdiction that you have listed, requesting that they complete and submit the form directly to the Department of Health.

☐ **4. Professional Education:**
List in date order, most recent to later, your educational preparation and post-graduate training. Attach additional pages if you need more space.

☐ **5. Professional Experience:**
List in date order all professional experience and practice from date of graduation from professional college. Attach additional pages if you need more space.

☐ **6. Qualifications Attestation:**
You must meet the qualification requirements. You must sign and date this application as proof of completion.

☐ **7. Endorsement Attestation:**
If you are applying by endorsement you must sign and date this for us to process the application. See **WAC 246-581-500**

☐ **8. Applicant's Attestation:**
You must sign and date this for us to process the application.

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

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Certification Requirements

Requirements for Licensure - See WAC 246-851-490:

To qualify for license in Washington, an applicant must:

- ☐ Successfully complete Parts I and II and Part III of the National Board of Examiners in Optometry (NBEO) Examinations.
  - If you completed the NBEO Part II prior to January 1, 1993, you must also successfully complete the International Association of Examiners in Optometry (IAB) examination in treatment and management of ocular disease (TMOD).
  - Part III must be successfully completed after January 1, 1993.

  Scores must be sent directly form the NBEO. For additional information on how to have your scores sent, go to the NBEO website at http://www.optometry.org/.
- ☐ Graduate from a state accredited high school or equivalent.
- ☐ Be of good moral character
- ☐ Graduate from a school or college of optometry accredited by the Council on Optometric Education of the American Optometric Association and approved by the Washington State Board of Optometry; Official transcripts must be submitted directly form the school or college of optometry with the degrees posted.
- ☐ Applicants who receive their license after January 1, 2007, must be licensed at the highest level. Specifically, applicants must meet requirements (a) through (e) above and also meet the requirements to use or prescribe topically applied drugs for diagnostic and therapeutic purposes (DPA and TPA), meet the requirements to use and prescribe oral drugs and meet the requirements for administration of injectable epinephrine.

Licensing By Endorsement:

An optometrist may be licensed without examination if the applicant is licensed in another state with licensing standards judged by the Board to be substantially equivalent to the standards in Washington. The application process is the same for examination or licensing. Candidates for licensing must provide a copy of the current law and regulation for the state from which they are coming. Applications for licensing by endorsement are reviewed on an individual basis by the Washington State Board of Optometry.

Certification To Use Topical Pharmaceutical Agents:

Required after January 1, 2007.

For diagnostics, applicants must provide documented evidence of sixty hours of approved didactic and clinical instruction in general and ocular pharmacology as applied to optometry. See **WAC 246-851-400**. Education must have occurred after July 1981.

For therapeutic purposes, applicants must provide documented evidence of an additional minimum of seventy-five hours of approved didactic and clinical instruction established by the Board. See **WAC 246-851-400**. Education must have occurred after July 23, 1989.

Certification for use or prescription of drugs administered orally for diagnostic or therapeutic purposes:

Required after January 1, 2007.

For orals, applicants must provide documented evidence he or she is certified to use or prescribe topical drugs for diagnostic and therapeutic purposes, and an additional minimum of sixteen hours of didactic and eight hours of supervised clinical instruction. See **WAC 246-851-570**. Education must have occurred after May 1, 2004

Certification for administration of epinephrine by injection for treatment of anaphylactic shock.

Required after January 1, 2007.

For injection of epinephrine, applicants must provide documented evidence he or she is certified to use or prescribe topical drugs for diagnostic and therapeutic purposes, and an additional minimum of four hours of didactic and supervised clinical instruction. See **WAC 246-851-600**. Education must have occurred after May 1, 2004.

Washington State Department of HEALTH

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Revenue 0261010000

Optometrist License Application

Please print clearly. It is the responsibility of the applicant to submit all supporting documentation. Failure to do so may result in a delay in processing your application.

Select if the following applies: ☐ Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	**National Provider Identifier Number (NPI)** (Enter 10 digit number)	☐ Male ☐ Female ☐ Prefer Not to Answer ☐ X

Name First Middle Last

Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	County

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address

Mailing address if different from above address of record

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No

If yes, list name(s):

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

   Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

   The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means within the past two years.

   "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

   Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

   If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.

   To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ☐ ☐
   b. Diverted controlled substances or legend drugs? ☐ ☐
   c. Violated any drug law? ☐ ☐
   d. Prescribed controlled substances for yourself? ☐ ☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? ☐ ☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ☐ ☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ☐ ☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ☐ ☐
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? ☐ ☐

3. Other License, Certification, or Registration

List all states where licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current. Attach additional pages if you need more space.

State/Jurisdiction	License Type	License Number	License		Method Licensed
			Issue Date	Expiration Date	

4. Professional Education

In the spaces below, provide a date listing of your educational preparation and post-graduate training. Attach additional pages if you need more space.

Schools Attended Full Name, City and State	Degree Earned	Attendance	
		From (mm/dd/yyyy)	To (mm/dd/yyyy)

5. Professional Experience

List in date order all professional experience and practice from date of graduation from professional college. Include the month/day/year. Attach additional pages if you need more space.

Nature of experience and location	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)

6. Qualifications and Training Attestation

I certify I have completed each of the requirements below.

- A high school diploma or equivalent;
- I am of moral character.

Applicant's Initials	Date

7. Endorsement Attestation (only required for endorsement applicants.)

I certify that I have read the following rules and laws pertaining to the practice of Optometry in Washington State as stated in **WAC 246-851-500**:

- **RCW 18.53**
- **RCW 18.54**
- **RCW 18.195**
- **RCW 18.130**
- **WAC 246-851**
- **WAC 246-852**

Applicant's Initials	Date

8. Applicant's Attestation

I,_____ , declare under penalty of perjury under the laws of the state
(Print applicant name clearly)

of Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ By: _____
(mm/dd/yyyy) (Original Signature of Applicant)

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Washington State Department of HEALTH
Optometry Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Optometry Certification for Diagnostic, Therapeutic and Oral Drugs

Applicant's Name_____
Specific requirements for license are on reverse side.

☐ **Diagnosis**—This is to certify the applicant has completed a minimum of sixty hours of didactic and clinical instruction in general and ocular pharmacology as established in WAC 246-851-400. **Education must be completed after July, 1981**

School Seal

Name of Accredited Institution_____

Date Education Completed _____

Signature _____

☐ **Treatment**—This is to certify the applicant has completed an additional minimum of seventy-five hours of didactic and clinical instruction as established in WAC 246-851-400. **Education for treatment purposes must be completed after July 23, 1989**

School Seal

Name of Accredited Institution_____

Date Education Completed _____

Signature _____

☐ **Oral—**This is to certify the applicant has completed an additional minimum of sixteen hours of didactic and eight hours of supervised clinical instruction from an institution of higher learning, accredited by those agencies recognized by the United States Office of Education or the Council on Postsecondary Accreditation as established in WAC 246-851-570. **Education for oral certification must be completed after May 1, 2004.**

School Seal

Name of Accredited Institution_____

Date Education Completed _____

Signature _____

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Optometry Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Optometry Certification for Administration of Epinephrine by Injection for Treatment of Anaphylactic Shock

Applicant Name: _____

☐ **Certification For Administration Of Epinephrine By Injection For Treatment Of Anaphylactic Shock**

A minimum of four hours of didactic and supervised clinical instruction as established in WAC 246-851-600 is required to administer epinephrine by injection for the treatment of anaphylactic shock in the scope of optometric practice. **Education must be completed after May 1, 2004.**

I certify the applicant has received a minimum of 4 hours of didactic and supervised clinical instruction as established in WAC 246-851-600.

School Seal

Name of Accredited Institution_____

Date Education Completed _____

Signature_____

WAC 246-851-600 Certification required for administration of epinephrine by injection for treatment of anaphylactic shock.

1. To qualify for certification to administer epinephrine by injection for anaphylactic shock, licensed optometrists must provide documentation he or she:
   A. Are certified under RCW 18.53.010 (2) (b) to use or prescribe topical drugs for diagnostic and therapeutic purposes.
   B. Have successfully completed a minimum of four hours of didactic and supervised clinical instruction from an institution of higher learning, accredited by those agencies recognized by the United States Office of Education or the Council on Postsecondary Accreditation to qualify for certification by the optometry board to administer epinephrine by injection.
2. The didactic instruction must include the following subject area:
   A. Review of urgencies, emergencies and emergency-use agents;
   B. Ocular urgencies:
      i. Thermal burns-direct and photosensitivity-based ultraviolet burn;
      ii. Electrical injury;
      iii. Cryo-injury and frostbite;
      iv. Insect stings and bites;
      v. Punctures, perforations, and lacerations;
   C. General urgencies and emergencies:
      i. Anaphylaxis;
      ii. Hypoglycemic crisis;
      iii. Narcotic overdose.
3. The supervised clinical instruction must include the following subject areas:
   A. Instrumentation;
   B. Informed consent;
   C. Preparation (patient and equipment);
   D. All routes of injections.
4. With the exception of the administration of epinephrine by injection for treatment of anaphylactic shock, no injections or infusions may be administered by an optometrist.

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RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Optometry Laws RCW 18.53

Optometry Rules, WAC 246-851

Topical Administration, WAC 246-851-400

Oral Administration, WAC 246-851-570

Online

Optometry Program, Web page