

APPLICATION TO PRACTICE OPTOMETRY

State of North Dakota
Board of Optometry
586 Park Street
Dickinson, ND 58601
701-690-7937

DATE OF APPLICATION: Day Month Year

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INSTRUCTIONS TO APPLICANT

1. Answer all questions completely, accurately, and legibly or the application will be returned.
2. The name you enter must exactly match the name on the supporting documents, or documentation of formal name change must be submitted.
3. All addresses must include zip code if requested on the application.
4. Required fee of \$200.00 must accompany application. **FEE IS NON-REFUNDABLE.**
5. Failure to answer all questions completely and accurately, and/or falsification of material facts may be cause for denial of your application, or disciplinary action if you are subsequently licensed by the Board.

TO: The North Dakota Board of Optometry

I hereby make application for registration to practice optometry in the State of North Dakota and submit the following statement concerning my birth, preliminary and optometry education and practice.

YOUR CURRENT NAME AND ADDRESS

FULL LEGAL NAME

STREET ADDRESS

CITY

STATE OR PROVINCE

ZIP CODE

COUNTRY

HOME PHONE

OTHER PHONE/CELL

GENDER

MAIDEN NAME

SOCIAL SECURITY OR ALEIN REGISTRATION NUMBER

OE TRACKER NUMBER

EMAIL ADDRESS

*******FOR BOARD USE ONLY*******

APPLICATION #	CHECK/RECEIPT #	BOARD ACTION
LICENSE #	AMOUNT PAID	BOARD DATE

RECORD OF BIRTH			
DATE OF BIRTH	CITY OF BIRTH	COUNTY OF BIRTH	STATE/PROVINCE OF BIRTH
FULL NAME OF FATHER		MOTHER'S MAIDEN NAME	

IDENTIFYING CHARACTERISTICS			
HEIGHT	WEIGHT	COLOR OF HAIR	COLOR EYES
IDENTIFYING MARKS			

PRELIMINARY EDUCATION				
NAME OF HIGH SCHOOL	CITY	STATE/PROVINCE	FROM DATE	TO DATE
NAME OF COLLEGE	CITY	STATE/PROVINCE	FROM DATE	TO DATE
NAME OF COLLEGE	CITY	STATE/PROVINCE	FROM DATE	TO DATE
NAME OF COLLEGE	CITY	STATE/PROVINCE	FROM DATE	TO DATE
TYPE OF DEGREE RECEIVED	NAME OF ISSUING SCHOOL		DATE DEGREE RECEIVED	
TYPE OF DEGREE RECEIVED	NAME OF ISSUING SCHOOL		DATE DEGREE RECEIVED	

OPTOMETRIC EDUCATION (OPTOMETRY SCHOOL MUST BE APPROVED BY BOARD)			
NAME OF SCHOOL	CITY	STATE/PROVINCE	GRADUATION DATE

PRACTICAL EXPERIENCE			
NAME OF FACILITY	LOCATION	FROM DATE	TO DATE
NAME OF FACILITY	LOCATION	FROM DATE	TO DATE
NAME OF FACILITY	LOCATION	FROM DATE	TO DATE

STATES/PROVINCES TO WHICH YOU HAVE MADE APPLICATION

STATE/PROVINCE	DATE OF APPLICATION	BASIS FOR APPLICATION	
		<u>Examination</u>	<u>Endorsement</u>

STATES/PROVINCES IN WHICH YOU ARE OR HAVE BEEN REGISTERED OR LICENSED

You must have each state complete a license verification form.

STATE/PROVINCE	LICENSE NUMBER	DATE ISSUED	EXPIRATION	HOW OBTAINED	
				<u>Examination</u>	<u>Endorsement</u>

MEMBERSHIP IN PROFESSIONAL SOCIETIES AND ORGANIZATIONS

NAME OF ORGANIZATION	FROM DATE	TO DATE

DOCUMENTATION TO BE SUBMITTED WITH APPLICATION

- _____ Certified copy of Birth Certificate
- _____ Certified transcript of optometric education (must show degree conferred)
- _____ Two (2) letters attesting to the moral and ethical character of the applicant.
 One letter is to be from a practicing optometrist in good standing who has personal knowledge of applicant.
- _____ Certified copy of N.B.E.O. examination results (may be electronically submitted)
 - _____ Part I, Basic Science
 - _____ Part II, Clinical Science
 - _____ Part III, Patient Care

IN ANSWERING THE FOLLOWING QUESTIONS, PLEASE CHECK THE APPROPRIATE ANSWER NEXT TO EACH QUESTION. IF NECESSARY, ATTACH ADDITIONAL SHEETS TO PROVIDE SUFFICIENT DETAIL. YOU MUST ANSWER ALL QUESTIONS WITH “YES” OR “NO”.

1. Have you ever had an application for a professional license denied?

2. Have you ever failed a licensing examination for a professional license?

3. Has any disciplinary action ever been instituted which could have affected or could now affect your license to practice in any state?

4. Have you ever been subject to informal or formal proceedings by any licensing board, agency, or professional association to revoke, suspend, or limit a professional license?

5. Are you now or have you ever been named as a defendant or respondent in any malpractice proceedings?

6. Have you ever been charged or received deferred prosecution or imposition of sentence of any crime, felony or misdemeanor?

7. Do you have or have you ever had any serious physical or mental illness?

8. Do you now or have you ever had problems with the use of alcohol, stimulants, or habit-forming drugs?

9. Have you ever been cited for operating a motor vehicle while under the influence of drugs or alcohol?

10. List all jurisdictions in which you have at any time been licensed to practice. Include the address of the licensing authority, dates of licensure, and license numbers.

11. Do you now, or have you ever had a D.E.A. registration number? If so, what is the number?

12. Have you ever entered a plea of “no contest” to a criminal charge of any kind? If so, what charge?_____

AFFIDAVIT OF APPLICANT:

STATE OF: _____

COUNTY OF: _____

_____ being first duly sworn, says that s/he is the person referred to in the above application for registration to practice optometry in the State of North Dakota, and that the statements herein contained are each and all strictly true in every respect.

Signature of Applicant

Sworn to before me this _____ day of _____, _____.

Signature of Notary

My Commission Expires: _____

Recent Photograph: (paste here)

North Dakota Board of Optometry

586 Park Street, Dickinson, ND 58601

(701) 690-7937

OPTOMETRY LICENSE CERTIFICATE

Please complete this form, with the requested information, for the printing of your official license to practice optometry in the State of North Dakota

I would like the following information to appear on my North Dakota Optometry License:

Name _____ O.D.
PLEASE PRINT

Town _____

Your official license certificate will be mailed to you following the Board meeting at which your application is reviewed, indicating the license number assigned to you.

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REQUEST FOR LICENSE VERIFICATION

APPLICANT: Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting verification of your license.

Applicant Name: _____ Date of Birth: _____

LICENSING JURISDICTION: Return completed form directly to the North Dakota Board of Optometry at the address listed above.

License #: _____ Date Issued: _____ Expiration Date: _____

Current License Status: Active _____ Inactive _____ Lapsed _____ Other _____

Licensed by: National Board Examinations
_____ State Written _____ Practical _____
Examination(s) _____
Waiver _____
Reciprocity/Endorsement _____ From which state _____

If licensed by state examination, provide subjects and scores.

SUBJECT	SCORE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Has this license ever been revoked, suspended, surrendered, restricted, limited, or placed on probation?

NO _____ YES _____ IF YES, PLEASE EXPLAIN ON REVERSE SIDE OR PROVIDE COPIES OF DISCIPLINARY ACTION TAKEN.

Is applicant currently under investigation or charged with a violation of the practice act?

NO _____ YES _____ IF YES, PLEASE EXPLAIN ON REVERSE SIDE.

FORM COMPLETED BY:

SIGNATURE

TITLE

DATE

STATE SEAL