APPLICATION TO PRACTICE OPTOMETRY

State of North Dakota
Board of Optometry
2222 E. Broadway Ave
Bismarck, ND 58501
701-471-0289

DATE OF APPLICATION:

Day	Month	Year

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	
		Examination	Endorsement

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	
				Examination	Endorsement

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 a 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 differed 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

2222 E. Broadway Ave. Bismarck, ND 58501
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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

STATE SEAL

_____
DATE