



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF EXAMINERS IN OPTOMETRY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

APPLICATION FOR LICENSURE AS A THERAPEUTIC OPTOMETRIST BY INTERNSHIP INSTRUCTION SHEET

When to Apply by Internship

File this application to request the Board's pre-approval of a six-month internship. Whether you are required to complete a six-month internship before you can be licensed as a Therapeutic Optometrist depends on whether you hold a *current* optometry license in another jurisdiction, how long you have practiced in that jurisdiction and whether that jurisdiction has licensure standards that are at least equal to Delaware's standards.

IF you...	AND IF you have...	THEN file this <i>Application</i> form:
do not hold a <i>current</i> license	--	<i>Therapeutic Optometrist by Internship</i>
hold a <i>current</i> license	not practiced at least five years in any single jurisdiction where you hold a current license	<i>Therapeutic Optometrist by Internship</i>
	practiced at least five years in any single jurisdiction where you hold a current license	<u>Therapeutic Optometrist by Reciprocity</u>

When you file an [Application for Licensure as a Therapeutic Optometrist by Reciprocity](#), the Board will determine whether any jurisdiction where you hold a current license **and** where you have practiced at least five years has licensure standards that are at least equal to Delaware's standards. If the Board determines that **none** of the jurisdictions has equivalent standards, you must re-apply by internship because you cannot be licensed by reciprocity.

Information about Internship

The internship period starts the day **after** the Board approves it. The period must consist of at least 35 hours per week for at least six months. You must be supervised throughout the period by one or more doctors approved by the Board.

It is your responsibility to select a doctor to supervise you during the internship. In making your selection, note the following:

- If the supervisor is neither an ophthalmologist nor therapeutically-certified optometrist, you must complete 100 additional hours of clinical internship with a therapeutically-certified optometrist, medical doctor or osteopathic physician.
- If you select a therapeutically-certified optometrist not licensed in Delaware, he or she must be licensed in a jurisdiction where the standards of therapeutic practice are comparable to those in Delaware.

If more than one doctor will be supervising you, the Board must approve all of them. A supervising doctor:

- must supervise you "one-on-one"
- can supervise only one intern at a time
- must be on the same premises and immediately available for supervision at all times
- must review the patient evaluations before the patient leaves the office.

These are examples of situations that are **not** acceptable direct supervision:

- The supervising doctor has two offices. He/she works in office 1, and the intern works in office 2.
- Three doctors work in the supervising doctor's office. The intern's Board-approved supervisor leaves and assigns a doctor whom the Board has *not* approved to supervise the intern.

Requirements for Approval of Internship

The following are required for pre-approval of the internship. Auxiliary forms mentioned are included with this application.

- Submit completed, signed and notarized [Application for Licensure as a Therapeutic Optometrist by Internship](#) to the Board office.
- Enclose [processing fee](#) by check or money order made payable to "State of Delaware."
- Arrange for the Board office to receive an official transcript from the college(s) of optometry where you received a degree, sent *directly* from the college to the Board office.
 - The transcript must show that you have received a degree of "Doctor of Optometry" from a legally incorporated and accredited optometric college or school accredited by the American Optometric Association.
- Submit a copy of front and back of your current cardio-pulmonary resuscitation (CPR) certification for adults and children.
- If you have ever held a license in another jurisdiction (state, U.S. territory or District of Columbia), arrange for the Board office to receive verification of licensure from each jurisdiction where you have ever held a license, sent *directly* from the jurisdiction to the Board office.
 - A *Verification of Optometry License* form is included with this application.
- Request a self-query from the National Practitioner and Healthcare Integrity and Protection Data Banks (NPDB/HIPDB) website at www.npdb-hipdb.hrsa.gov. The self-query report will be mailed to your address. When you receive the report, mail (do not fax) the **original report** to the Board office.
- Arrange for the Board office to receive a notarized *Statement of Supervising Doctor* form completed and signed by *each* doctor who will supervise you during your internship, sent *directly* from the supervising doctor to the Board office.
 - If more than one doctor will supervise you, each must submit a separate statement.
- If you have never been issued a U.S. Social Security Number (SSN), submit a [Request for Exemption from Social Security Number Requirement](#).
 - *The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants:* Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 Del. C. §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 Del. C. §2216) and for other lawful purposes.

In addition to the requirements above, the Board office must also receive an official report of your passing scores on the National Board of Examiners in Optometry (NBEO) examination Parts I - III and TMOD. Since NBEO sends each candidate's score report to all jurisdictions, the Board office will generally have received your score reports before you file your application. For information about the exam, see the NBEO website at www.optometry.org

Requirement for Approval of License *Following* Internship

When the internship period is complete, **each** supervising doctor must verify that you successfully completed your internship. Generally, the Board will review these verifications at the scheduled Board meetings **closest** to the end of your internship. This is to assure that you receive your permanent license as soon as possible after your internship ends.

- Arrange for the Board office to receive verification that you have successfully completed your internship, preferably on the *Verification of Internship* form, from **each** supervising doctor.
 - If the internship end date falls **after** the closest Board meeting, the supervising doctor(s) should submit a preliminary *Verification of Internship* form for the Board's review at its meeting and a second, final *Verification of Internship* form on or after the internship end date.
 - If the internship end date falls **before** the closest Board meeting, the supervising doctor(s) should submit the final *Verification of Internship* form before the meeting. In this situation, the Board office may extend the internship period to cover the days leading up to the meeting.

The Board will review the verifications at its meeting and, if you have successfully completed the internship and met all requirements, the Board will approve your Therapeutic Optometrist licensure. The Board office will then issue your Therapeutic Optometrist license.



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APPLICATION FOR LICENSURE AS A THERAPEUTIC OPTOMETRIST BY INTERNSHIP

IDENTIFYING AND CONTACT INFORMATION

- Full Name: _____
Last/Family First Middle
- Other Names Used: _____
(Include maiden, former married names and alternate spellings.)
- Date of Birth (month/day/year): _____ Gender: Male Female
- Have you been issued a U.S. Social Security Number? Yes No
 - If yes, enter your SSN: _____
 - If no, you must file a [Request for Exemption from Social Security Number Requirement](#).
- Mailing Address: _____

City State Zip
- Phone: _____ Email: _____
daytime evening or cell

EDUCATION AND EXAMINATIONS

- Enter the following information about **each** college of optometry you attended:

COLLEGE	CITY, STATE/PROVINCE, COUNTRY	DEGREE OR CERTIFICATE	DATE RECEIVED

Arrange for the Board office to receive an official transcript from the college(s) of optometry where you received a degree, sent *directly* from the college to the Board office.

- Have you passed all parts of the NBEO examination **and** the TMOD? Yes No
- Do you hold current certification to perform CPR on adults and children? Yes No

Submit a copy of front and back of your current CPR certification for adults and children.

INTERNSHIP INFORMATION

- When do you plan to begin practicing in Delaware? _____

Note: Do not begin practicing in Delaware before the start date of the Board-approved internship.

11. Enter this information about the practice where you plan to serve your internship.

Practice Name: _____

Location Address: _____

_____ City State Zip

12. Enter the following information about **each** doctor who will supervise your internship:

NAME	TYPE OF DOCTOR			DELAWARE LICENSED?
	<input type="checkbox"/> Ophthalmologist	<input type="checkbox"/> Therapeutic Optometrist	<input type="checkbox"/> Other	Yes <input type="checkbox"/> No <input type="checkbox"/>
	<input type="checkbox"/> Ophthalmologist	<input type="checkbox"/> Therapeutic Optometrist	<input type="checkbox"/> Other	Yes <input type="checkbox"/> No <input type="checkbox"/>
	<input type="checkbox"/> Ophthalmologist	<input type="checkbox"/> Therapeutic Optometrist	<input type="checkbox"/> Other	Yes <input type="checkbox"/> No <input type="checkbox"/>
	<input type="checkbox"/> Ophthalmologist	<input type="checkbox"/> Therapeutic Optometrist	<input type="checkbox"/> Other	Yes <input type="checkbox"/> No <input type="checkbox"/>
	<input type="checkbox"/> Ophthalmologist	<input type="checkbox"/> Therapeutic Optometrist	<input type="checkbox"/> Other	Yes <input type="checkbox"/> No <input type="checkbox"/>

Arrange for the Board office to receive a notarized *Statement of Supervising Doctor* form completed and signed by *each* doctor who will supervise you during your internship, sent directly from the supervising doctor to the Board office.

LICENSURE HISTORY

13. Have you ever held a license to practice optometry in another jurisdiction (state, U.S. territory or District of Columbia)? Yes No If yes, List *each* jurisdiction where you have *ever* held, a license. If you need more room, enclose a separate sheet.

JURISDICTION	LICENSE NUMBER	ISSUE DATE	EXPIRATION DATE

Arrange for a verification of licensure to be sent *directly* to the Board office from *each* jurisdiction listed.

DISCLOSURES

- 14. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense, including any offense for which you have received a pardon, in any jurisdiction? Yes No **If yes, submit a certified copy of your criminal history record.**
- 15. Have you ever had your professional license or certificate subject to disciplinary action (including, but not limited to, consent agreements, fines, probation, suspension or revocation) in any jurisdiction? Yes No **If yes, enclose a statement explaining fully.**
- 16. Has any jurisdiction ever rejected your application or revoked your professional license or certificate? Yes No **If yes, enclose a statement explaining fully.**
- 17. Are any complaints currently pending against you in any jurisdiction? Yes No **If yes, enclose a statement explaining fully.**
- 18. Have you excessively used or abused drugs, including alcohol, narcotics or chemicals? Yes No **If yes, enclose a statement explaining fully. Include copies of all appropriate records.**

Request a self-query from the National Practitioner and Healthcare Integrity and Protection Data Banks (NPDB/HIPDB) website at www.npdb-hipdb.hrsa.gov. The self-query report will be mailed to your address. When you receive the report, mail the *original report* to the Board office.

DUTY TO REPORT

19. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to file a written report with the Board of Medical Licensure and Discipline within 30 days if you have any reason to believe that a medical practitioner *other than yourself* is (or may be) guilty of unprofessional conduct as defined in 24 Del. C. §1731 OR that he/she is (or may be):
- medically incompetent
 - mentally or physically unable to engage safely in the practice of medicine
 - excessively using or abusing drugs including alcohol.

I certify that I have read and understand the provisions of [24 Del. C. §1730, 24 Del. C. §1731 and 24 Del. C. §1731A](#) and that I understand my *duty to report*. Yes No

20. To obtain a license in Delaware, you must certify that you understand that you have a **mandatory** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

I certify that I have read and understand [16 Del. C. §903](#) and that I understand my *duty to report*. Yes No

To assure that your application is ready for Board review, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board’s meeting date:

- Completed, signed and notarized application form
- Fee payment
- All required supporting documentation.

Applications that are not complete within six months of filing may be considered abandoned and discarded.

Please note: When your internship is complete, please allow 2 weeks to receive your license.

AFFIDAVIT

I certify that the information in this application is complete and true. I understand that the intentional inclusion of false or fraudulent information in this application, or the material omission of information which might have a bearing on licensure, may result in the denial of licensure and will be reported to the Attorney General for further action. I understand that the application fee is not refundable.

Signature of Applicant: _____ **Date:** _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Signature of Notary: _____

SEAL

My commission expires: _____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.



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**OPTOMETRY INTERNSHIP
STATEMENT OF SUPERVISING DOCTOR**

INFORMATION AND INSTRUCTIONS

When an internship **pre-approved** by the Delaware Board of Examiners in Optometry is a requirement for Delaware optometry licensure, **each** doctor who will be supervising the intern is required to complete, sign and submit a *Statement of Supervising Doctor* form. Note that the statement must be notarized. Mail it *directly* to the Board office at the address above.

The internship period starts the day **after** the Board approves it. The period must consist of at least 35 hours per week for at least six months. The intern must be supervised throughout the period by a Board-approved doctor(s).

It is the intern's responsibility to select a doctor to supervise him or her during the internship. Note the following:

- If the supervisor is neither an ophthalmologist nor therapeutically-certified optometrist, the intern must complete 100 additional hours of clinical internship with a therapeutically-certified optometrist, medical doctor or osteopathic physician.
- If the supervisor is a therapeutically-certified optometrist not licensed in Delaware, he or she must be licensed in a jurisdiction where the standards of therapeutic practice are comparable to those in Delaware.

If more than one doctor will be supervising the intern, the Board must approve all of them. Each supervising doctor:

- must supervise the intern "one-on-one"
- can supervise only one intern at a time
- must be on the same premises and immediately available for supervision at all times
- must review the patient evaluations before the patient leaves the office.

These are examples of situations that are **not** acceptable direct supervision:

- The supervising doctor has two offices. He/she works in office 1, and the intern works in office 2.
- Three doctors work in the supervising doctor's office. The intern's Board-approved supervisor leaves and assigns a doctor whom the Board has *not* approved to supervise the intern.

INTERN NAME: _____

INFORMATION ABOUT SUPERVISING DOCTOR

1. Name: _____

2. Check your license type: Optometrist Ophthalmologist Other Medical Doctor Osteopathic Physician

If you are an optometrist, continue with Question 3. Otherwise, skip to Question 4.

3. Are you therapeutically certified in any jurisdiction where you are licensed, including Delaware? Yes No If yes, enter the following information about **each** jurisdiction where you therapeutically certified:

JURISDICTION	LICENSE NUMBER

4. Practice Name: _____
 Practice Address: _____

 City State Zip

5. Will other optometrists or physicians in your practice supervise the intern at any time? Yes No If yes, list the names of **all** supervising doctors: _____

Each supervising doctor must complete a *Statement of Supervising Doctor* form.

INFORMATION ABOUT INTERNSHIP

Note: The internship does not begin until the Board approves the dates.

6. Enter the **requested** start and end dates of the internship:
 Start (month/year): _____ End (month/year): _____

7. Is this internship part of a residency? Yes No If yes, enter the start and end dates of the residency:
 Start (month/year): _____ End (month/year): _____

8. What will be the intern's duties? _____

9. What are the internship goals? _____

10. How many hours per week will the intern work? _____ hours

11. How many hours per week will you **personally** supervise the intern? _____ hours

12. Will the intern practice at any location other than the one you entered in Question 4? Yes No If yes, enter **each** address where the intern will practice and the number of hours per week he or she will work at each location:

LOCATION	HOURS PER WEEK

13. Does your practice have any other interns? Yes No

AFFIDAVIT

I certify that the information in this statement is complete and true.

Signature of Supervising Doctor: _____ **Date:** _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Signature of Notary: _____

SEAL

My commission expires: _____

Mail this form directly to the Board office.



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VERIFICATION OF COMPLETION OF INTERNSHIP

INFORMATION AND INSTRUCTIONS

When the internship period is complete, **each** supervising doctor must verify that the intern successfully completed his or her internship. The Board office will contact the intern before the internship's end date to coordinate receiving these verifications for review during the scheduled Board meeting closest to the end of the internship. If the end date falls after the Board meeting, the Board office may ask supervising doctor(s) to submit a preliminary letter before the meeting and a second, final letter after the meeting. This is to assure that the intern receives his or her permanent license as soon as possible after the internship ends.

The Board will review the verifications at its meeting and, if the intern has successfully completed the internship and met all requirements, the Board will approve his or her Therapeutic Optometrist licensure to begin the day after your internship ends. The Board office will issue the Therapeutic Optometrist license.

Complete and sign this form. Mail it *directly* to the Board office at the address above.

INTERN NAME: _____

1. Supervising Doctor Name: _____

2. Practice Name: _____

Practice Address: _____

_____ City _____ State _____ Zip

3. Enter the start and end dates of the internship:

Start (month/year): _____ End (month/year): _____

4. I certify that during the internship period the intern named above

- worked at least 35 hours per week Yes No
- was supervised one-on-one Yes No
- has completed the duties for the internship Yes No
- has met the goals of the internship Yes No

5. I certify that the intern named above has successfully completed the required six-month internship for licensure as an optometrist in Delaware. Yes No

Signature of Supervising Doctor: _____ **Date:** _____

Mail this form directly to the Board office.



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VERIFICATION OF OPTOMETRIST LICENSE

Send a separate form to *each* jurisdiction other than Delaware where you have ever held an optometry license.

Licensing Authority: _____ Address: _____ City/State/Zip: _____	Applicant Name: _____ Home Address: _____ City/State/Zip: _____
Applicant completes this section	Last Name: _____ First: _____ Middle: _____ SSN: _____ Date of Birth: _____ Other Name(s) Used: _____ License Number(s) in Jurisdiction Named Above: _____ <p>I am applying for licensure as a Therapeutic Optometrist in the State of Delaware. Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the Delaware Board of Examiners in Optometry .</p> Applicant Signature: _____ Date: _____
Licensing authority completes this section	Our records indicate that the applicant named above was licensed in the State/Province/Jurisdiction of _____ License Number: _____ Issue Date (month/day/year): _____ Expiration Date : _____ (month/day/year) _____ Has any discipline activity taken place regarding this licensee? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, enclose a certified copy of the Board Order with this license verification.
AFFIX OFFICIAL SEAL HERE	<p>I certify that the information above is an accurate account of this person's records and is true and correct.</p> Printed Name of Official: _____ Signature of Official: _____ Date: _____ Title: _____ Phone: _____ Fax: _____ Email: _____

Mail (do not fax) completed, signed and sealed form *directly* to the Board office at the address above.