

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 RECIPROCITY INSTRUCTION SHEET

When to Apply by Reciprocity

File this application for licensure by reciprocity if you

- hold a *current* optometry license in another jurisdiction (state, U.S. territory or District of Columbia), **and**
- have practiced at least five years in any single jurisdiction where you hold a current license.

If you do not meet **both** of these criteria, you must complete a six-month internship before you can be licensed as a Therapeutic Optometrist. To request the Board's pre-approval of a six-month internship, file the [Application for Licensure as a Therapeutic Optometrist by Internship](#).

When you file the [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. Since Delaware issues only Therapeutic Optometrist licenses, the Board will evaluate both the *basic licensure standards* **and** *standards of therapeutic practice* of each jurisdiction. It is possible that the basic licensure standards are equivalent to those of Delaware, but the standards of therapeutic practice are not. If the Board determines that **none** of the jurisdictions has equivalent basic and therapeutic standards, you must re-apply by internship because you cannot be licensed by reciprocity.

Requirements for All Applicants

The following are required to apply by reciprocity. Auxiliary forms mentioned are included with this application.

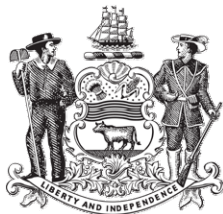
- Submit completed, signed and notarized [Application for Licensure as a Therapeutic Optometrist by Reciprocity](#) to the Board office.
- Enclose [processing fee](#) by check or money order made payable to "State of Delaware."
- Arrange for the Board office to receive an official transcript from the 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.
- If you passed the National Board of Examiners in Optometry (NBEO) examination *before 2007*, arrange for the Board office to receive an official report of your passing scores on Parts I - III and TMOD, sent *directly* from NBEO to the Board office.
 - If you passed the NBEO in 2007 or later, the Board office generally will have already received your score report from NBEO. If it does not have your scores, the Board office will notify you to request a score report.
 - For information about the exam and requesting score reports, see the NBEO website at www.optometry.org
- 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.

- Submit copies of the current optometry license law and rules and regulations from **each** jurisdiction where you hold a *current* license **and** where you have practiced at least five years.
 - The Board will compare Delaware's basic licensure standards and standards of therapeutic practice to those of each jurisdiction.

- 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 verification of your practice in any jurisdiction where you hold a *current* license **and** you have practiced at least five years.
 - The verification letters must come from persons in a position to know your practice history, such as employer, colleague or accountant. They must be sent *directly* from the person to the Board office.
 - Since you will not know at the time you file this application which jurisdictions where you hold a current license, if any, have licensure standards equivalent to those of Delaware, it is preferable to obtain this documentation of your practice in *each* jurisdiction where you hold a current license and you have practiced five years.

- 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.



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APPLICATION FOR LICENSURE AS A THERAPEUTIC OPTOMETRIST BY RECIPROCITY

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

If you passed the NBEO examination *before 2007*, arrange for the Board office to receive an official report of your passing scores on Parts I - III and TMOD, sent *directly* from NBEO to the Board office.

- 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.

LICENSURE HISTORY

10. List *each* jurisdiction (state, U.S. territory or District of Columbia) where you have *ever* held, a license to practice optometry. 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.

PRACTICE HISTORY

11. Enter the following information about your practice in each jurisdiction where you hold a *current* optometry license.

EMPLOYER/PRACTICE NAME	ADDRESS	TYPE OF PRACTICE (e.g., Therapeutic Optometrist)	EMPLOYMENT DATES	
			From	To

Arrange for the Board office to receive verification of your practice in any jurisdiction where you hold a *current* license *and* you have practiced at least five years. The verification must come from persons in a position to know your practice history and must be sent *directly* from the person to the Board office. In addition, submit copies of the current optometry license law and rules and regulations from *each* jurisdiction where you hold a *current* license *and* where you have practiced at least five years.

DISCLOSURES

- 11. 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.**
- 12. 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.**
- 13. Has any jurisdiction ever rejected your application or revoked your professional license or certificate? Yes No **If yes, enclose a statement explaining fully.**
- 14. Are any complaints currently pending against you in any jurisdiction? Yes No **If yes, enclose a statement explaining fully.**
- 15. 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

16. 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

17. 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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VERIFICATION OF OPTOMETRIST LICENSE

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

Licensing Authority: _____		Applicant Name: _____	
Address: _____		Home Address: _____	
City/State/Zip: _____		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	I certify that the information above is an accurate account of this person's records and is true and correct.		
	Printed Name of Official: _____		
	Signature of Official: _____		Date: _____
	Title: _____		
	Phone: _____		Fax: _____

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