

**FLORIDA BOARD OF OPTICIANRY  
4052 BALD CYPRESS WAY, BIN #C08  
TALLAHASSEE, FLORIDA 32399-3258  
(850) 245-4474**

**Application for Optical Establishment Permit**

Please indicate the reason for completing the application and submit the non-refundable fee. A separate application must be completed for each establishment.

Please check the appropriate reason for this application.

- Registration and licensure of a new establishment \$100.00(Change of ownership requires new registration.)
- Change of physical location \$25.00 (duplicate license fee)
- Change of name of establishment \$25.00 (duplicate license fee)

**Complete all sections of the application. Incomplete applications will delay processing.  
Please type or print neatly.**

**ESTABLISHMENT INFORMATION:**

I. Name of Establishment: \_\_\_\_\_

II. Name of Owner or Agent: \_\_\_\_\_ SS# or FED ID# \_\_\_\_\_  
(The Department is required and authorized to collect social security numbers relating to applications for professional licensure pursuant to Title 42 USCA § 666(a)(13). For all professions regulated under Chapter 456, Florida Statutes, the collection of social security numbers is required by section 456.013(1)(a), Florida Statutes.)

Mailing Address: \_\_\_\_\_  
(Street) (Telephone Number)  
\_\_\_\_\_  
(City) (State) (Zip)

III. Location Address of Establishment: \_\_\_\_\_  
(Street)  
\_\_\_\_\_  
(City) (State) (Zip) (County - required)

\_\_\_\_\_  
(Required: Print Name of Contact Person) (Required: Telephone Number of Establishment)  
\_\_\_\_\_  
Name of Licensed Optician

**If this is a location address change, please provide the old address:**

\_\_\_\_\_  
(Street) (Telephone Number)  
\_\_\_\_\_  
(City) (State) (Zip) (County)

**IV. APPLICANT HISTORY - Pursuant to Section 456.0635(2), Florida Statutes,**

**IMPORTANT NOTICE:** Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer YES to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the address below. Supporting documentation includes court dispositions or agency orders where applicable.

1. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? <b>(If you responded "no", skip to #2.)</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO
a. If "yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?	<input type="checkbox"/> YES <input type="checkbox"/> NO
b. If "yes" to 1, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).	<input type="checkbox"/> YES <input type="checkbox"/> NO
c. If "yes" to 1, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?	<input type="checkbox"/> YES <input type="checkbox"/> NO
d. If "yes" to 1, has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "yes", please provide supporting documentation).	<input type="checkbox"/> YES <input type="checkbox"/> NO
2 Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
a. If "yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? <b>(If "No", do not answer 3a.)</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO
a. If the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant has been terminated but reinstated, has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been in good standing with the Florida Medicaid Program for the most recent five years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? <b>(If "No", do not answer 4a or 4b.)</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO
a. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been in good standing with a state Medicaid program for the most recent five years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
b. Did the termination occur at least 20 years before to the date of this application?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	<input type="checkbox"/> YES <input type="checkbox"/> NO

**CERTIFICATION**

I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind. I declare that these statements are true and correct and recognize that providing false information may result in disciplinary action pursuant to s. 456.067, F.S., or criminal penalties pursuant to s. 775.082, s. 775.083, or s. 775.085, F.S. Should I furnish any false information on this application, I hereby acknowledge that such act may constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida.

I further declare that I am familiar with the laws and rules regulating Optical Establishments and that this facility meets the requirements of Chapter 484, Part I, Florida Statutes, and the Rules of the Board of Opticianry and Optical Establishments in 64B12 and 64B29, Florida Administrative Code, and that this facility will be operated in compliance with all applicable laws and rules.

I understand that it is my responsibility to keep informed of any changes to Chapters 456 and 484, Part I, Florida Statutes, and the rules in 64B12 and 64B29, Florida Administrative Code.

\_\_\_\_\_  
Typed or Printed Name of Owner or Agent

\_\_\_\_\_  
Signature of Owner or Agent

\_\_\_\_\_  
Date