# Wisconsin Department of Safety and Professional Services

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## OPTOMETERY EXAMINING BOARD

## DPA/TPA CERTIFICATION APPLICATION FOR OPTOMETRISTS WHO HELD A WISCONSIN LICENSE PRIOR TO AUGUST 1, 2006

- If you are applying for DPA certification only, complete DPA requirement section along with physician referral list and page 3.
- If you are DPA certified and are applying for TPA certification, complete TPA requirement section, and rest of app.
- If you are applying for both certifications, complete whole application.
- If you are DPA/TPA certified and are submitting referral changes only, complete referral section, and page 3 of 3.

**PLEASE TYPE OR PRINT IN INK** ☐ Your name, address, telephone and electronic address are available to the public. Check box to withhold address, telephone number, and email address from lists of 10 or more credential holders (Wis. Stat. § 440.14).

**Last Name** | **First Name** | **MI** | **Former / Maiden Name(s)**

**Address:** (number, street, city, zip code)

**Daytime Phone Number:** ___ - ___ - ____ **Date of Birth:** __ / __ / ____

**WI Optometry License #:** _____ - 35

**DPA REQUIREMENTS:**

You must have your school of optometry or the National Board of Examiners, as appropriate; submit proof of your having fulfilled the requirements in 1 and 2 below:

**1. 60 Classroom Hours of General/Ocular Pharmacology**

List Optometry College: List Graduation Date: __ __ / __ __ / ____

30 of the 60 hours were in ocular pharmacology. ☐ YES ☐ NO

50-60 minute periods. ☐ YES ☐ NO

**2. Examinations** (one of the following)

A. **National Board Examination Option:** (check one of the following)

Section 9 ☐ YES ☐ NO

Clinical Pharmacology ☐ YES ☐ NO

Parts I and II (administered after 1986 only) ☐ YES ☐ NO

**B. School Exam Option:**

DPA courses and exam ☐ YES ☐ NO

Verification from the school must state that you have completed the DPA course and have passed the course examinations. The verification must also include a description of the course content and examination content.

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**TPA REQUIREMENTS:**

**1. 100-Hour Board-Approved Post-graduate Course**

List Course Provider/Sponsor:

List Course Name:

List Course Dates Attended:

__/__ to __/__

Achieved a minimum passing score.

☐ YES ☐ NO

**AND/OR:**

**2. Board-Approved Exam** (IAB/TMOD/NBEO)

List Course Provider/Sponsor:

List Course Name:

List Examination Date:

__/__/____

Achieved a minimum score of 75.

☐ YES ☐ NO

**DPA/TPA ADVERSE DRUG REACTION REFERRAL PLAN FOR OPTOMETRISTS:**

"Adverse Drug Reaction" means: an adverse, physical or psychological reaction experienced by a person resulting from diagnostic or therapeutic pharmaceutical agents administered by an optometrist which occurs within 24 hours after the drug is administered. An adverse drug reaction may be indicated by symptoms, which include, but are not limited to, the following: red eye, painful eye, decrease in vision, pale or red swelling of the periocular or periorbital tissues, nausea, vomiting, fainting, mental confusion, or cessation of respiration.

"Adverse Drug Reaction Referral Plan" means a plan submitted to the Department in which the optometrist agrees to:

1. Advise the patient to immediately contact the optometrist if they experience an adverse reaction;
2. Refer patients with an adverse drug reaction to appropriate medical specialists or facilities;
3. Record the drug reaction in the patient's permanent file, describing any adverse drug reactions experienced by the patient, the date and time that any patient referral was made; and
4. Report all referrals to the Department on TPA Adverse Reaction Report (**Form #1728**) **within 10 working days of the occurrence.**

**PHYSICIAN, PHYSICIAN CLINIC OR HOSPITAL LIST:**

Specify below three (3) physicians, physician clinics, and/or hospitals to which patients will be referred in the event of an adverse reaction to a drug administered by the optometrist. At least one physician specified must be skilled in the diagnosis and treatment of diseases of the eye. A revised adverse drug reaction plan must be filed with the Department within **10 working days** if a new physician, physician clinic, or hospital is designated for referrals. Contact the Board office for additional form(s) to note change(s) and resubmit.

**Name:** (Physician, Clinic, or Hospital)

**Address:** (number, street, city, zip code)

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**Address:** (number, street, city, zip code)

**CERTIFICATION OF LEGAL STATUS:**

I declare under penalty of law that I am (check one):

☐ A citizen or national of the United States, or

☐ A qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. Seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.

Should my legal status change during the application process or after a credential is granted, I understand that I must report this change to the Wisconsin Department of Safety and Professional Services immediately.

**CONTINUING DUTY OF DISCLOSURE:**

I understand that I have a continuing duty of disclosure during the application process. If information I have provided in this application becomes invalid, incorrect or outdated, I understand that I am obliged to provide any necessary information to ensure the information on my application remains current, valid, and truthful. I understand that Credentialing authorities may view acts of omission as dishonesty and that my duty of disclosure during the application process exists until licensure is granted or denied.

**AFFIDAVIT OF APPLICANT:**

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal, or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause of disciplinary action.

By signing below, I am signifying that I have read the above statements (Certification of Legal Status, Continuing Duty of Disclosure, and Affidavit of Applicant) and understand the obligation I have as an applicant or credential-holder should information I've provided to the Department of Safety and Professional Services change.

Signature _____ Date __ __ / __ __ / __ __ __ __

(Print and Sign Form)