

Wisconsin Department of Safety and Professional Services

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Office Location: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: <http://dsps.wi.gov>

OPTOMETRY EXAMINING BOARD

INSTRUCTIONS TO APPLICANTS FOR WISCONSIN OPTOMETRY LICENSURE

AN APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

1. **Complete the application (Form #598) and appropriate fees.** Checks or money orders should be made payable to the Department of Safety and Professional Services. Your canceled check will be your receipt
2. **Complete Wisconsin Statutes and Rules exam.**
3. **In Addition to the Application Form (#598) and Fee, the Following Supporting Documents must be forwarded to the Board Office:**
 - Certified transcript from a Board-approved optometric college indicating the date of graduation and degree granted.
 - Verification of licensure from all other state(s)/jurisdiction(s) in which you are/were licensed (if any).
 - Verification of passing **Parts I, II, III and passing the Treatment and Management of Ocular Disease (TMOD)** examination of the National Board of Examiners in Optometry examination. A certified transcript must be submitted directly to the Department.

The Wisconsin Optometry Examining Board requires Parts I, II, III and passing the Treatment and Management of Ocular Disease (TMOD) (Patient Care Examination) of National Boards to be taken **prior** to application for the Wisconsin licensure examination.

ENDORSEMENT CANDIDATES PRACTICING FIVE (5) OR MORE YEARS:

Candidates applying for licensure as an optometrist in Wisconsin through endorsement must have practiced optometry for **at least five (5) years** in another state.

- If you engaged in the practice of optometry for at least five (5) years prior to January 1, 1996, you must submit evidence of five (5) years of experience and verification of successful completion of Parts I and II of the National Board of Examiners in Optometry (NBEO) examination.
- If you graduated from an approved college of optometry after December 1, 1995, you must submit evidence of five (5) years of experience and verification of successful completion of Parts I, II and III and passing the Treatment and Management of Ocular Disease (TMOD) of the National Board of Examiners in Optometry (NBEO) examination.

All supporting documents must be received from the institutions. They will not be accepted from the candidate.

APPROVED OPTOMETRY COLLEGES AND CORRESPONDING CODES:

<u>School Name</u>	<u>School Code</u>	<u>School Name</u>	<u>School Code</u>
Ferris State - Big Rapids MI	23001	Southern CA College of Opt - Fullerton CA	05001
Illinois College of Opt - Chicago IL	14001	Southern College of Opt - Memphis TN	43001
Indiana University - Bloomington IN	15001	State Univ. of New York - New York City NY	33001
Inter American U of Puerto Rico - San Juan PR	16001	University of Alabama - Birmingham AL	01001
New England College of Opt - Boston MA	22001	University of California - Berkeley CA	05002
Northeastern State Univ. - Tahlequah OK	17001	University of Houston - Houston TX	44001
Nova Southeastern Univ. - N Miami Beach FL	18001	University of Waterloo - Ontario Canada	52001
Ohio State University - Columbus OH	36001	University of Missouri - St Louis MO	26001
PA College of Opt at Salas Univ - Elkins Park PA	39001	University of Montreal - Quebec Canada	19001
Pacific University - Forest Grove OR	38001	Univ. of the Incarnate Word Rosenberg Sch of Opt - San Antonio TX	003578
Midwestern Univ. AZ College of Opt - Glendale AZ	00906	Western Univ. of Health Sciences College of Opt. - Romona CA	024827

Wisconsin Department of Safety and Professional Services

If you held a Wisconsin optometrist license prior to August 1, 2006 complete Form #1161 (DPA/TPA Application) and follow instructions on (Form #2132).

DPA REQUIREMENTS:

An applicant must request **a letter** from the optometry college of graduation, which is accredited by the American Council on Optometric Education and approved by the Wisconsin Optometry Examining Board, listing the following information:

- successful completion of 60 classroom hours in general and ocular pharmacology, 30-hours of which must have been in ocular pharmacology, emphasizing the systemic effects and treatment for adverse reactions;
- the classroom hours must have been 50-60 minute periods of lecture, group discussion and/or laboratory, associated with the course;
- your graduation date;
- the title or position of the college official; and
- the school seal.

In addition to the classroom requirement, the following supporting documentation of successful completion of the National Board of Examiners in Optometry (NBEO) must be forwarded to the Board office:

- Applicants who took the NBEO exam prior to 1988: verification of successful completion of Part II, Section 9 with a minimum score of 75;
- Applicants who took the NBEO exam after 1988 and prior to 1994: verification of successful completion of Part II, Clinical Pharmacology with a minimum score of 75;
- Applicants who apply for a certificate after April 1, 1994: verification of successful completion of Parts I and II administered after 1986; or
- Successful completion of a post-graduate DPA course and exam approved by the Wisconsin Optometry Examining Board and sponsored by an accredited optometry college.

TPA REQUIREMENTS:

Applicants must be DPA-certified and also must have **successfully completed** one of the following requirements:

- graduates prior to 1987: verification of 100 hour board-approved post-graduate course and exam given by course provider since January 1, 1987 **OR** 100-hour board-approved post-graduate course and the IAB or TMOD exam;
- graduates between 1987-1991: verification of TMOD or IAB/NBEO exam **OR** successful completion of a 100 hour board-approved post-graduate course and exam given by course provider; or,
- graduates from 1992 to present: TMOD or NBEO exam.

Proof of completion of one of the above-listed items must be submitted for TPA certification.

Supporting documents for the DPA/TPA requirements must be submitted directly from the institutions. Documents will not be accepted from the applicant.

STATE LAW EXAMINATION:

The Wisconsin Optometry State Law Exam is an open book examination on the Wisconsin Statutes and Administrative Codes that govern optometrists.

Information regarding the examination and a copy of the Statutes and Administrative Code are available online at dsps.state.wi.gov. Candidates who pass the Wisconsin Optometry State Law Examination will not be notified of their successful completion of the exam. Failing candidates will receive notice of their score and a new examination to complete. In addition, a retake examination fee will be required.

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OPTOMETRY EXAMINING BOARD

APPLICATION FOR OPTOMETRIST LICENSE

The Department must deny your application if you are liable for delinquent state taxes, UI contributions, or child support (Wis. Stat. §§ 440.12 and 440.13).

PLEASE TYPE OR PRINT IN INK Your name, address, telephone number, and email 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 <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Former / Maiden Name(s) <input type="text"/>
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Address (street, city, state, zip) <input type="text"/>	Daytime Telephone Number <input type="text"/> - <input type="text"/> - <input type="text"/>
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Mailing Address (if different) <input type="text"/>	Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>
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Social Security Number <input type="text"/> - <input type="text"/> - <input type="text"/>	Your Social Security Number or Employer Identification Number must be submitted with your application on this form. If you do not have a Social Security Number, you must complete Form #1051. The Department may not disclose the Social Security Number collected except as authorized by law.
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Ethnicity/gender status information is optional.

Ethnicity: White, not of Hispanic origin American Indian or Alaskan Hispanic
 Black, not of Hispanic origin Asian or Pacific Islander Other

Sex: M F

Have you ever been licensed in Wisconsin as an Optometrist? Yes No If yes, list your credential number:

Email Address

School Name <input type="text"/>	School Address (street, city, state) <input type="text"/>
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Date Degree Granted <input type="text"/> / <input type="text"/> / <input type="text"/>	Degree <input type="text"/>
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APPLICATION FEES: Please check applicable box. Make check payable to DSPS and attach to this application.

- I am seeking a Veteran Fee Waiver** (for Initial Credential Fee only, see page 2 for further information)
- Exam Applicants (EPPP and State Law Exam)**
 \$ 75.00 Initial Credential Fee
 \$ 75.00 State Law Exam
\$150.00 Total Fee Attached
- Endorsement Applicants**
 \$ 75.00 Endorsement Credential Fee
 \$ 75.00 State Law Exam
\$150.00 Total Fee Attached

For Receiving Use Only (35)

Wisconsin Department of Safety and Professional Services

APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Application (Form #598) and appropriate fee <input type="checkbox"/> Wisconsin Statutes and Rules exam <input type="checkbox"/> Certified transcript from a board-approved optometric college indicating the date of graduation and degree granted. <input type="checkbox"/> Letters from all State Boards where licensed, active and inactive <input type="checkbox"/> A certified transcript indicating successful completion of the National Boards (Parts I, II, III and TMOD) examinations must be submitted to the Optometry Board. | <ul style="list-style-type: none"> <input type="checkbox"/> Convictions and Pending Charges (Form #2252), if applicable <input type="checkbox"/> Malpractice Suits or Claims (Form #2829) and copies of malpractice suit, court documents with allegations and settlement, if applicable <input type="checkbox"/> Is name on all credentials the same? If not, submit certified copy of marriage certificate, divorce decree, etc. |
|---|---|

ARE YOU A VETERAN? If yes, please view the Department website at <https://dsps.wi.gov/Pages/Professions/MilitaryLicensureBenefits.aspx> for eligibility requirements.

If you qualify, are you requesting a waiver of your initial credentialing fee? Yes No

If Yes, provide a copy of your Department of Veterans Affairs voucher code and list your DVA Voucher Code Number:

If you qualify, are you requesting equivalency of your Military Training and experience? Yes No

If Yes, complete and return the Veteran Request Application Addendum (**Form #2996**). This form must be included with this application.

If you qualify, are you requesting Temporary Spousal Reciprocal License? Yes No

If Yes, do not complete this form. You must complete and return the Application for Temporary Spousal Reciprocal License (**Form #2982**).

You may contact the DVA at 1-800-WisVets or www.WISVETS.com for assistance in obtaining your DVA Voucher Code and/or documents related to your training.

CONTINUING EDUCATION AND RENEWAL REQUIREMENTS: Please view the Department website at <http://dsps.wi.gov> and select "Professions," then "Optometrist."

I AM OR HAVE BEEN LICENSED IN THE FOLLOWING STATE(S). (Include all active and inactive states.)

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For each credential listed above, you are required to have each State Board or territory of the United States submit a letter of verification to the Wisconsin Optometry Examining Board. The verification letter(s) must state your date of birth, credential number, date of issuance, and a statement regarding disciplinary actions.

REGARDING THE STATES YOU LISTED ABOVE: Identify the states in which you were licensed by EXAM.

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PRACTICE:

If you engaged in the practice of optometry for at least five (5) years prior to January 1, 1996, you must submit evidence of five (5) years of experience and verification of successful completion of Parts I and II of the National Board examination.

If you graduated from an approved college of optometry after December 1, 1995, you must submit evidence of five (5) years of experience and verification of successful completion of Parts I, II, III and TMOD of the National Board examination. (Attach additional sheets if necessary.)

Employer/Institution/Activity	Location of Employment (City/State)	Dates Employed (Month/Year)	The Capacity in Which You Are/Were Employed
	(City) <input style="width: 100%; height: 20px;" type="text"/> (State) <input style="width: 20px; height: 20px;" type="text"/>	(From) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/>	
	(City) <input style="width: 100%; height: 20px;" type="text"/> (State) <input style="width: 20px; height: 20px;" type="text"/>	(From) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> (To) <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/>	

Wisconsin Department of Safety and Professional Services

TPA/DPA CERTIFICATION:

If you held a Wisconsin optometrist license prior to August 1, 2006 complete (Form #1161) and follow the instructions on (Form #2132).

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.

TPA REQUIREMENTS:

1. 100-Hr 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

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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)

Name: (Physician, Clinic, or Hospital)

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

Name: (Physician, Clinic, or Hospital)

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

Wisconsin Department of Safety and Professional Services

ANSWER THE FOLLOWING QUESTIONS. (Attach additional sheets if necessary.)

1.	Have you ever surrendered, resigned, canceled, or been denied a professional license or other credential in Wisconsin, or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you ever failed to pass any state board examination, national board examination? If yes, provide details below: (Original pass/fail scores required.) <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to any warning, reprimand, suspension, probation, limitation, or revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Have you ever been convicted of a misdemeanor, felony, or other violation of federal, state, or local law or do you have any felony, misdemeanor or other violation of federal, state, or local law charges pending against you in this state or any other? This includes municipal ordinances resulting only in monetary fines or forfeitures and convictions resulting from a plea of no contest, a guilty plea, or verdict. If yes, submit Convictions and Pending Charges (Form #2252).	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Are you incarcerated, on probation, or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Have any suits or claims ever been filed against you as a result of professional services? If yes, Malpractice Suits or Claims (Form #2829).	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what state(s): <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? If yes, give details on an attached sheet.	<input type="checkbox"/> Yes <input type="checkbox"/> No

For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice optometry" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned optometry judgments and to learn and keep abreast of optometry developments; and
2. The ability to communicate those judgments and optometry information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech and hearing impairments, Cerebral Palsy, epilepsy, Muscular Dystrophy, Multiple Sclerosis, cancer, heart disease, Diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical Substances" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of Controlled Dangerous Substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances, which are not obtained pursuant to a valid prescription, or not taken in accordance with the directions of a licensed health care practitioner.

Wisconsin Department of Safety and Professional Services

ANSWER THE FOLLOWING QUESTIONS. (Attach additional sheets if necessary.)

11.	Do you have a medical condition, which in any way impairs or limits your ability to practice optometry with reasonable skill and safety? If no, you may skip questions 12 and 13. If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	If yes to question 11, are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	If yes to question 11, are the limitations or impairments caused by your medical condition reduced, or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
14.	Does your use of chemical substance(s) in any way impair, or limit your ability to practice optometry with reasonable skill and safety? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	Have you ever been diagnosed as having, or have you ever been treated for pedophilia, exhibitionism, or voyeurism? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	Are you currently engaged in the illegal use of controlled dangerous substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	If yes to question 16, are you currently participating in a supervised rehabilitation program or professional assistance program, which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
18.	If yes to question 5 above, did you apply for a predetermination of the convictions? If YES, proceed to question 19. If NO, submit Convictions and Pending Charges Form #2252 and supporting documentation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
19.	If yes to question 18, did you receive an approval letter? If YES, proceed to question 20. If NO, submit Convictions and Pending Charges Form #2252 and supporting documentation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
20.	If yes to question 19, since the date of your approval letter have you been convicted of a misdemeanor, felony, or other violation of federal, state, or local law or do you have any felony, misdemeanor or other violation of federal, state, or local law charges pending against you in this state or any other? This includes municipal ordinances resulting only in monetary fines or forfeitures and convictions resulting from a plea of no contest, a guilty plea, or verdict. If YES, submit Convictions and Pending Charges Form #2252 and supporting documentation. If NO, do not submit Convictions and Pending Charges Form #2252.	<input type="checkbox"/> Yes <input type="checkbox"/> No

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: ____/____/____