



MEDICAL BOARD OF CALIFORNIA Licensing Program



APPLICATION CHECKLIST FOR REGISTRATION AS A DISPENSING OPTICIAN (RDO)

Prior to filling out the application, please review [California Business & Professions Code sections 2550-2559](#) as they pertain to a RDO.

Please use the checklist below to ensure that your application is complete prior to forwarding to the Medical Board of California.

- ☐ \$75 registration fee is included. (Make checks payable to Medical Board of California.)
- ☐ The application is legibly and completely filled out, signed and notarized, and that any necessary documents are attached to the application.
- ☐ If applying as a corporation, the corporation's Articles of Incorporation **and** a list of officers are included.
- ☐ If you are submitting an RDO application because of a change of ownership, ensure that the Cancellation of Registration form has been completed by the previous owner and is included with your application.
- ☐ Please make sure that you have provided accurate information regarding the individual who will serve as the contact in the event of a customer or Board inquiry. It is preferable that an individual working at the store is designated as the contact. For corporations electing to use headquarter employees as contacts, please note that certificates, renewals, and other correspondence are sent to the store's address of record (business location) unless designated otherwise in question five of the RDO application.

Tips:

- Each store location requires a separate application.
- Please allow eight weeks for the review of a **complete and legible** application. You will be notified in writing if any additional items or information is needed.
- You may wish to make and retain copies of the materials submitted to the Medical Board.



MEDICAL BOARD OF CALIFORNIA

Licensing Program

APPLICATION FOR REGISTRATION AS A DISPENSING OPTICIAN

Please **READ** all instructions prior to completing this application. **ALL** questions on this application must be answered, and **all** supporting documents must be submitted as per instructions. Please type or print neatly. When space provided is insufficient, attach additional sheets of paper. All attachments are considered part of the application. A separate application is required for each business location.

**Registration is not transferable. Previous owner must complete a
Cancellation of Certificate form prior to a new registration being approved**

APPLICATION FOR REGISTRATION AS A DISPENSING OPTICIAN		FOR OFFICE USE ONLY	
Please print or type. Illegible applications will be returned.		Fee paid: _____ Receipt #: _____ Date Cashiered: _____ Cashier's Intl.: _____ Date Approved: _____ Reg. No.: _____ Date Denied: _____	
1. Complete business name under which you will be doing business:			
2. Complete Business Address:		Street _____ City _____ State _____ Zip _____	
3. Telephone/Fax Number:		Telephone: () _____ Fax: () _____	
4. The applicant is: (Check only one box)		<input type="checkbox"/> Individual (Sole Proprietor) <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation (Attach a copy of the Articles of Incorporation and a list of officers)	
5. For corporations only , check this box if you would like to have the renewal forms and all correspondence (excluding the certificates of registration) mailed to the corporate address <u>specified</u> on page two of this form.* <input type="checkbox"/>			
6. Social Security Number or Federal/Taxpayer ID Number:			
7. The business will be filling prescriptions for (check all that apply): <input type="checkbox"/> Spectacle Lenses <input type="checkbox"/> Contact Lenses			
List the name, address, and registration number of each person responsible for overseeing the fitting and adjusting of the above:			
Name	Address	Registration #	
8. List the name, address, and telephone number of the person designated to handle customer or Medical Board inquiries and complaints:			
Name	Address	Telephone #	

*If this box is not checked, all forms and correspondence will be sent to the business address.

The Medical Board of California requests this information. Failure to provide any of the requested information may result in this application being rejected as incomplete. The information provided will be used to determine your eligibility for registration per Section 2552 of the Business and Professions Code, which authorizes the collection of this information. The Licensing Program chief is the custodian of records. Access to records by the individual to whom they pertain may be obtained under the Information Practices Act by contacting the custodian of records at the above address. Information in this application may be transferred to other governmental or law enforcement agencies.

Disclosure of your Social Security Number (SSN) or Federal Employer Identification Number (FEIN) is mandatory. Corporations are exempt from this requirement. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your SSN or FEIN. Your SSN or FEIN will be used for tax enforcement purposes, for compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your SSN or FEIN, your application will not be processed and you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.

BOTH PAGES OF THIS FORM MUST BE COMPLETED.

9. **FOR INDIVIDUAL OR PARTNERSHIP:** Information below to be completed by each owner.

a. Name _____ Address _____
Signature _____ Title _____ Date _____

b. Name _____ Address _____
Signature _____ Title _____ Date _____

FOR CORPORATIONS: Information below to be completed by the corporation president or secretary.

I am an officer of _____ (Complete name of corporation) and as such, make the declaration below for and on behalf of said corporation.

Name _____ Title _____
Corporation Address _____
Street _____ City _____ State _____ Zip _____
Signature _____ Date _____

10. **Applicant's Declaration/Signature and Notary** (To be completed in the presence of a notary by an owner/officer named above.)

I, _____, being first duly sworn upon his/her oath deposes and says:
(PLEASE **PRINT** FULL NAME OF OWNER/OFFICER)

that I declare under penalty of perjury under the laws of the State of California that: (1) the business described herein will not advertise the furnishing of, or furnish, the services of a refractionist, an optometrist, or a physician and surgeon; directly or indirectly employ or maintain on or near the premises used for optical dispensing, a refractionist, an optometrist, a physician and surgeon, or a practitioner of any other profession for the purpose of any examination or treatment of the eyes (B&P § 2556), (2) the business described herein will not have any membership, proprietary interest, co-ownership, landlord-tenant relationship, or any profit sharing arrangement in any form directly or indirectly with an optometrist (B&P § 655), (3) the business described herein will not fill any prescription issued by a physician and surgeon who has any proprietary interest, or has designated or arranged for any other person to have any proprietary interest in the business described herein (B&P § 2553.6), (4) the business described herein will not have any membership, proprietary interest or co-ownership in any form with a physician and surgeon to whom patients, clients or customers are referred or any profit-sharing arrangement (B&P § 654).

Further, that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury under the laws of the State of California, that all of the information contained herein and attached thereto are true and correct. I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A REGISTRATION.

SIGNATURE OF OWNER/OFFICER: _____
(PLEASE **SIGN** FULL NAME)

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on

this _____ day of _____, 20____,

by: (Owner/Officer name to be printed here)

proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL

SIGNATURE OF NOTARY PUBLIC