CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF EXAMINERS IN OPTOMETRY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR LICENSURE AS A THERAPEUTIC OPTOMETRIST BY INTERNSHIP
INSTRUCTION SHEET

When to Apply by Internship

File this application to request the Board's pre-approval of a six-month internship. Whether you are required to complete a six-month internship before you can be licensed as a Therapeutic Optometrist depends on whether you hold a *current* optometry license in another jurisdiction, how long you have practiced in that jurisdiction and whether that jurisdiction has licensure standards that are at least equal to Delaware's standards.

IF you…	**AND IF** you have…	**THEN** file this *Application* form:
do ***not*** hold a *current* license	--	*Therapeutic Optometrist by Internship*
hold a *current* license	***not*** practiced at least five years in any single jurisdiction where you hold a current license	*Therapeutic Optometrist by Internship*
	practiced at least five years in any single jurisdiction where you hold a current license	*Therapeutic Optometrist by Reciprocity*

When you file an *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. If the Board determines that ***none*** of the jurisdictions has equivalent standards, you must re-apply by internship because you cannot be licensed by reciprocity.

Information about Internship

The internship period starts the day ***after*** the Board approves it. The period must consist of at least 35 hours per week for at least six months. You must be supervised throughout the period by one or more doctors approved by the Board.

It is your responsibility to select a doctor to supervise you during the internship. In making your selection, note the following:

- If the supervisor is neither an ophthalmologist nor therapeutically-certified optometrist, you must complete 100 additional hours of clinical internship with a therapeutically-certified optometrist, medical doctor or osteopathic physician.
- If you select a therapeutically-certified optometrist not licensed in Delaware, he or she must be licensed in a jurisdiction where the standards of therapeutic practice are comparable to those in Delaware.

If more than one doctor will be supervising you, the Board must approve all of them. A supervising doctor:

- must supervise you "one-on-one"
- can supervise only one intern at a time
- must be on the same premises and immediately available for supervision at all times
- must review the patient evaluations before the patient leaves the office.

These are examples of situations that are ***not*** acceptable direct supervision:

- The supervising doctor has two offices. He/she works in office 1, and the intern works in office 2.
- Three doctors work in the supervising doctor's office. The intern's Board-approved supervisor leaves and assigns a doctor whom the Board has *not* approved to supervise the intern.

Requirements for Approval of Internship

The following are required for pre-approval of the internship. Auxiliary forms mentioned are included with this application.

☐ Submit completed, signed and notarized *Application for Licensure as a Therapeutic Optometrist by Internship* to the Board office.

☐ Enclose the 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.

☐ Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.

☐ Submit a copy of the 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.

☐ 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 a notarized *Statement of Supervising Doctor* form completed and signed by *each* doctor who will supervise you during your internship, sent directly from the supervising doctor to the Board office.

- If more than one doctor will supervise you, each must submit a separate statement.

☐ 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.

In addition to the requirements above, the Board office must also receive an official report of your passing scores on the National Board of Examiners in Optometry (NBEO) examination Parts I - III and TMOD. Since NBEO sends each candidate's score report to all jurisdictions, the Board office will generally have received your score reports before you file your application. For information about the exam, see the NBEO website at www.optometry.org

Requirement for Approval of License *Following* Internship

When the internship period is complete, ***each*** supervising doctor must verify that you successfully completed your internship. Generally, the Board will review these verifications at the scheduled Board meetings ***closest*** to the end of your internship. This is to assure that you receive your permanent license as soon as possible after your internship ends.

☐ Arrange for the Board office to receive verification that you have successfully completed your internship, preferably on the *Verification of Internship* form, from ***each*** supervising doctor.

- If the internship end date falls ***after*** the closest Board meeting, the supervising doctor(s) should submit a preliminary *Verification of Internship* form for the Board's review at its meeting and a second, final *Verification of Internship* form on or after the internship end date.
- If the internship end date falls ***before*** the closest Board meeting, the supervising doctor(s) should submit the final *Verification of Internship* form before the meeting. In this situation, the Board office may extend the internship period to cover the days leading up to the meeting.

The Board will review the verifications at its meeting and, if you have successfully completed the internship and met all requirements, the Board will approve your Therapeutic Optometrist licensure. The Board office will then issue your Therapeutic Optometrist license.

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APPLICATION FOR LICENSURE AS A THERAPEUTIC OPTOMETRIST BY INTERNSHIP

IDENTIFYING AND CONTACT INFORMATION

1. Full Name: _____ _____ _____
   Last/Family First Middle

2. Other Names Used: _____ _____ _____
   (Include maiden, former married names and alternate spellings.)

3. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

4. 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*.

5. Mailing Address: _____

   _____ _____ _____
   City State Zip

6. Phone: _____ _____ Email: _____
   daytime evening or cell

EDUCATION AND EXAMINATIONS

7. Enter the following information about ***each*** college of optometry you attended:

COLLEGE	CITY, STATE/PROVINCE, COUNTRY	DEGREE OR CERTIFIICATE	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.

8. Have you passed all parts of the NBEO examination ***and*** the TMOD? Yes ☐ No ☐

9. 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.

INTERNSHIP INFORMATION

10. When do you plan to begin practicing in Delaware? _____

    Note: Do not begin practicing in Delaware before the start date of the Board-approved internship.

11. Enter this information about the practice where you plan to serve your internship.

Practice Name: _____

Location Address: _____

_____ _____ _____
City State Zip

12. Enter the following information about ***each*** doctor who will supervise your internship:

NAME	TYPE OF DOCTOR	DELAWARE LICENSED?
	☐ Ophthalmologist ☐ Therapeutic Optometrist ☐ Other	Yes ☐ No ☐
	☐ Ophthalmologist ☐ Therapeutic Optometrist ☐ Other	Yes ☐ No ☐
	☐ Ophthalmologist ☐ Therapeutic Optometrist ☐ Other	Yes ☐ No ☐
	☐ Ophthalmologist ☐ Therapeutic Optometrist ☐ Other	Yes ☐ No ☐
	☐ Ophthalmologist ☐ Therapeutic Optometrist ☐ Other	Yes ☐ No ☐

Arrange for the Board office to receive a notarized *Statement of Supervising Doctor* form completed and signed by *each* doctor who will supervise you during your internship, sent directly from the supervising doctor to the Board office.

LICENSURE HISTORY

13. Have you ever held a license to practice optometry in another jurisdiction (state, U.S. territory or District of Columbia)? Yes ☐ No ☐ If yes, List *each* jurisdiction where you have *ever* held, a license. 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.

DISCLOSURES

14. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or other criminal offense in any jurisdiction, including any offense for which you have received a pardon? Yes ☐ No ☐ **If yes, submit a signed statement explaining fully.**

Arrange for the Board office to receive State of Delaware and Federal Bureau of Investigation criminal background checks. The State Bureau of Identification will send the reports directly to the Board office. *This requirement applies even if you answered "No" to this question*.

15. Are criminal charges pending against you in any jurisdiction? Yes ☐ No ☐ **If yes, submit a letter explaining fully. Include copies of all appropriate records.**

16. 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.**

17. Has any jurisdiction ever rejected your application or revoked your professional license or certificate? Yes ☐ No ☐ **If yes, enclose a statement explaining fully.**

18. Are any complaints currently pending against you in any jurisdiction? Yes ☐ No ☐ **If yes, enclose a statement explaining fully.**

19. 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

20. 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 ☐

21. 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. 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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OPTOMETRY INTERNSHIP

STATEMENT OF SUPERVISING DOCTOR

INFORMATION AND INSTRUCTIONS

When an internship ***pre-approved*** by the Delaware Board of Examiners in Optometry is a requirement for Delaware optometry licensure, ***each*** doctor who will be supervising the intern is required to complete, sign and submit a *Statement of Supervising Doctor* form. Note that the statement must be notarized. Mail it *directly* to the Board office at the address above.

The internship period starts the day ***after*** the Board approves it. The period must consist of at least 35 hours per week for at least six months. The intern must be supervised throughout the period by a Board-approved doctor(s).

It is the intern's responsibility to select a doctor to supervise him or her during the internship. Note the following:

- If the supervisor is neither an ophthalmologist nor therapeutically-certified optometrist, the intern must complete 100 additional hours of clinical internship with a therapeutically-certified optometrist, medical doctor or osteopathic physician.
- If the supervisor is a therapeutically-certified optometrist not licensed in Delaware, he or she must be licensed in a jurisdiction where the standards of therapeutic practice are comparable to those in Delaware.

If more than one doctor will be supervising the intern, the Board must approve all of them. Each supervising doctor:

- must supervise the intern "one-on-one"
- can supervise only one intern at a time
- must be on the same premises and immediately available for supervision at all times
- must review the patient evaluations before the patient leaves the office.

These are examples of situations that are ***not*** acceptable direct supervision:

- The supervising doctor has two offices. He/she works in office 1, and the intern works in office 2.
- Three doctors work in the supervising doctor's office. The intern's Board-approved supervisor leaves and assigns a doctor whom the Board has *not* approved to supervise the intern.

INTERN NAME: _____

INFORMATION ABOUT SUPERVISING DOCTOR

1. Name: _____

2. Check your license type: ☐ Optometrist ☐ Ophthalmologist ☐ Other Medical Doctor ☐ Osteopathic Physician

   If you are an optometrist, continue with Question 3. Otherwise, skip to Question 4.

3. Are you therapeutically certified in any jurisdiction where you are licensed, including Delaware? Yes ☐ No ☐ If yes, enter the following information about ***each*** jurisdiction where you therapeutically certified:

JURISDICTION	LICENSE NUMBER

4. Enter the following information about the practice where the internship will be served:

   Practice Name: _____

   Practice Address: _____

   _____ _____ _____
   City State Zip

5. Will other optometrists or physicians in your practice supervise the intern at any time? Yes ☐ No ☐ If yes, list the names of ***all*** supervising doctors: _____ _____

   _____ _____ _____

   Each **supervising doctor must complete a** ***Statement of Supervising Doctor*** **form.**

INFORMATION ABOUT INTERNSHIP

6. Enter the ***requested*** start and end dates of the internship:

   Start (month/year): _____ End (month/year): _____

Note: The internship does not begin until the Board approves the dates.

7. Is this internship part of a residency? Yes ☐ No ☐ If yes, enter the start and end dates of the residency:

   Start (month/year): _____ End (month/year): _____

8. What will be the intern's duties? _____

9. What are the internship goals? _____

   _____

10. How many hours per week will the intern work? _____ hours

11. How many hours per week will you ***personally*** supervise the intern? _____ hours

12. Will the intern practice at any location other than the one you entered in Question 4? Yes ☐ No ☐ If yes, enter *each* address where the intern will practice and the number of hours per week he or she will work at each location:

LOCATION	HOURS PER WEEK

13. Does your practice have any other interns? Yes ☐ No ☐

AFFIDAVIT

I certify that the information in this statement is complete and true.

Signature of Supervising Doctor: _____ 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: _____

Mail this form directly to the Board office.

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VERIFICATION OF COMPLETION OF INTERNSHIP

INFORMATION AND INSTRUCTIONS

When the internship period is complete, ***each*** supervising doctor must verify that the intern successfully completed his or her internship. The Board office will contact the intern before the internship's end date to coordinate receiving these verifications for review during the scheduled Board meeting closest to the end of the internship. If the end date falls after the Board meeting, the Board office may ask supervising doctor(s) to submit a preliminary letter before the meeting and a second, final letter after the meeting. This is to assure that the intern receives his or her permanent license as soon as possible after the internship ends.

The Board will review the verifications at its meeting and, if the intern has successfully completed the internship and met all requirements, the Board will approve his or her Therapeutic Optometrist licensure to begin the day after your internship ends. The Board office will issue the Therapeutic Optometrist license.

Complete and sign this form. Mail it *directly* to the Board office at the address above.

INTERN NAME: _____

1. Supervising Doctor Name: _____

2. Practice Name: _____

   Practice Address: _____

   _____ _____ _____
   City State Zip

3. Enter dates of the internship: Start (month/year): _____ End (month/year): _____

4. I certify that during the internship period the intern named above
   - worked at least 35 hours per week Yes ☐ No ☐
   - was supervised one-on-one Yes ☐ No ☐
   - has completed the duties for the internship Yes ☐ No ☐
   - has met the goals of the internship Yes ☐ No ☐

5. I certify that the intern named above has successfully completed the required six-month internship for licensure as an optometrist in Delaware. Yes ☐ No ☐

Signature of Supervising Doctor: _____ Date: _____

Mail this form directly to the Board office.

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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:_____ Address:_____ City/State/Zip: _____	Applicant Name: _____ Home Address: _____ 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: _____ **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 .** **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 ☐ No ☐ **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:** _____ **Email:**_____

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

Revised 6/2014

Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 9 am – 7 pm, Tue - Fri 9 am – 3 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(Between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Delaware State Police Troop Four
South DuPont Hwy & Shortley Rd.
Georgetown DE 19947
(Across from DelDOT & the State Service Ctr.)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants Residing in Delaware

1. If you are using the New Castle or Sussex Counties locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.
2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $69.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. *Personal checks are not accepted in any county.* As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Out-of-State Applicants

1. You can be fingerprinted by your local police agency. All types of fingerprint cards are accepted. If your local police agency cannot provide a fingerprint card, call **(302) 739-2134** to request a fingerprint card.
2. Your *Authorization for Release of Information* form and fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, sex, etc.), your form will be returned.
3. ***Mail*** the *Authorization* form, fingerprint card, and certified check or money order (*personal checks are not accepted*) for $69.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

⇨***ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.***

DO NOT SEND THE FORM OR FEE TO THE BOARD OFFICE

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CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

AUTHORIZATION FOR RELEASE OF INFORMATION

Please print or type all information in black ink.

Check the type of license for which you are applying:

- ☐ Adult Entertainment
- ☐ Charitable Gaming Vendor
- ☐ Chiropractic
- ☐ Dental
- ☐ Massage
- ☐ Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT)
- ☐ Nursing (RN, LPN, APN)
- ☐ Nursing Home Administrator
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Pharmacy
- ☐ Physical Therapy/Athletic Trainer
- ☐ Podiatry
- ☐ Psychology
- ☐ Real Estate Appraiser (includes Appraisal Management Company)
- ☐ Speech/Hearing
- ☐ Social Work
- ☐ Texas Hold'em Individual
- ☐ Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers)

Print your current full name:

_____	_____	_____	_____
Last Name	First Name	Middle Initial	Suffix (e.g., Jr., Sr.)

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ Date: _____

Phone: Home _____ Work _____

Mail the results of my criminal history request to:

Division of Professional Regulation
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

Revised 6/2014