Virginia Department of Health Professions
Board of Optometry

Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Email: optbd@dhp.virginia.gov
Phone: (804) 597-4132
Fax: (804) 793-9145
Website: https://www.dhp.virginia.gov/Boards/Optometry/

BOARD OF OPTOMETRY

INSTRUCTIONS FOR REINSTATING A LICENSE AFTER DISCIPLINARY ACTION TO PRACTICE AS A TPA-CERTIFIED OPTOMETRIST

READ THE FOLLOWING INFORMATION CAREFULLY BEFORE PROCEEDING

- **Laws and Regulations**: Application requires an attestation to having read the applicable laws and regulations.
- **Application processing**: An initial email will be sent acknowledging receipt of application and notification of missing documentation. An application to reinstate a license after disciplinary action requires additional steps to determine if the applicant is prepared to resume practice in a safe and competent manner. For issues related to the application, send email to optbd@dhp.virginia.gov.
- **Application and Fee:** Application and fee must be submitted together by postal mail. An application fee of **$500.00** is required; make check or money order payable to the "Treasurer of Virginia." **All fees are nonrefundable**.
- **License expiration dates:** Licenses will expire on March 31 of the current renewal cycle in which the license is reinstated.
- **Board Communication:** The Board's method of communication with applicants is via email.

You may qualify for reinstatement of licensure if you meet the requirements below and submit the required documentation:

❑ Option 1

- Licensure verification of all licenses ever held, including expired, in another U.S. jurisdiction. At least one current, active license in another U.S. jurisdiction is required for this reinstatement option. (**NOTE**: Staff will obtain license verifications from U.S. jurisdictions that provide online primary source verification that includes disciplinary history. An applicant is responsible for requesting license verifications from jurisdictions that do not have an online verification system. The other jurisdiction is required to send the verification directly to the Board preferably via email at optbd@dhp.virginia.gov.)
- Evidence of being engaged in active clinical practice within the 12 months immediately preceding application for reinstatement. Active practice may be verified on the Board's optional Employment Verification Form, company letterhead or tax returns (1040) and must be sent directly from employer to the Board at optbd@dhp.virginia.gov.

❑ Option 2

- Submit documentation of CE (copies of completed certificates or OETracker transcript) as specified in 18VAC105-20-70 equal to the requirement for the number of years in which the license has lapsed, not to exceed 40 contact hours (20 hours/year).
- Licensure verification of all licenses ever held, including expired, in another U.S. jurisdiction. . (**NOTE**: Staff will obtain license verifications from U.S. jurisdictions that provide online primary source verification that includes disciplinary history. An applicant is responsible for requesting license verifications from jurisdictions that do not have an online verification system. The other jurisdiction is required to send the verification directly to the Board preferably via email at optbd@dhp.virginia.gov.)

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APPLICATION FOR REINSTATEMENT AFTER DISCIPLINE OF A TPA-CERTIFIED OPTOMETRY LICENSE

Full Name (Please Print or Type)

Last:	First:	Middle Initial:

Have you ever been known by any other name? Yes ☐ No ☐ If yes, state in full every name by which you have been known. If the name stated above does not match name on required documentation, a copy of legal name change (i.e. marriage license or divorce) is required.

Other Names:

Public Address for Disclosure:	City:	State:	Zip Code:	Telephone Number:
Address of Record: (Mailing Address)	City:	State:	Zip Code:	Telephone Number:

ADDRESS: Virginia law allows persons regulated by boards within the Department of Health Professions to provide an alternative address for public disclosure if they want their address of record to remain confidential, used only for agency purposes. Health professionals may choose to provide a work address, a post office box, or a home address as the public address. If an alternative public address is not provided, the address of record will also be used as the public address and may be disclosed if specifically requested. Addresses of individuals **are not posted** on the "License Lookup" program available through the board's website.

*Social Security No. or Virginia DMV No.	Date of Birth (mm/dd/yyyy)	Email Address: Public ☐ Private ☐

List OETracker Number:

Are you active-duty military?	**YES** ☐	**NO** ☐
Are you the spouse of a member of the U.S. military who has been transferred to Virginia and who had to leave employment to accompany your spouse to Virginia?	**YES** ☐	**NO** ☐
Are you relocating to Virginia or an adjoining state or the District of Columbia with a spouse who is 1) On federal active duty orders; or 2) A veteran who has left active duty service within one year of submission of this application?	**YES** ☐ **YES** ☐	**NO** ☐ **NO** ☐

Graduation Date (mm/dd/yyyy)	Professional Degree(s)	School	State

*In accordance with §54.1-116 Code of Virginia, you are required to submit your Social Security Number or your control number** issued by the Virginia Department of Motor Vehicles. If you fail to do so, the processing of your application will be suspended and fees will not be refunded. This number will be used by the Department of Health Professions for identification and will not be disclosed for other purposes except as provided by law. Federal and state law requires that this number be shared with other state agencies for child support enforcement activities. **In order to obtain a Virginia driver's license control number, it is necessary to appear in person at an office of the Department of Motor Vehicles in Virginia. A fee and disclosure to DMV of your Social Security Number will be required to obtain this number.

APPLICANTS DO NOT USE SPACES BELOW THIS LINE – FOR OFFICE USE ONLY

ORIGINAL ISSUE DATE: _____ EXPIRATION DATE: _____

APPLICANT #	FEE	RECEIPT #	LICENSE #	ISSUE DATE

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Have you been actively engaged in the practice of optometry prior to seeking reinstatement of licensure in Virginia?	**YES** ☐	**NO** ☐

List all professional practice in reverse chronological order. A resume or CV is acceptable.

Begin Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Name of Employer/City/State/Phone	Type of Practice

List all U.S. jurisdictions in which you have ever held a license, including expired, to practice optometry. If more space is needed, please record on separate paper.

Jurisdiction	License #	Issue Date (mm/dd/yyyy)	Years of Practice	License Status(expired/active/inactive/revoked/suspended)

LICENSURE QUESTIONS
ALL QUESTIONS MUST BE ANSWERED

Have you ever been denied an optometry license? If yes, please provide a full explanation that includes the type of license, the jurisdiction and the date of denial and submit notices, orders, etc., from the regulatory authority authorized to take such actions?	**YES** ☐	**NO** ☐
Have you ever had any of the following disciplinary actions taken against your license in another jurisdiction to practice optometry? (a) suspension (b) revocation (c) probation (d) reprimand (e) had your practice monitored (e) monetary penalty? If yes, submit notices, orders, etc. from the regulatory authority authorized to take such actions.	**YES** ☐	**NO** ☐
Have you ever been convicted of a violation of/or pled Nolo Contendere to any federal, state, or local statute, regulation, or ordinance, or entered into any plea bargaining relating to a felony or misdemeanor? Including convictions for driving under the influence; excluding traffic violations. Additionally, any information concerning an arrest, charge, or conviction that has been sealed, including arrests, charges, or convictions for possession of marijuana, does not have to be disclosed. Attach your original criminal history record, a certified copy of any final order, decree, or case decision by a court or regulatory agency with lawful authority to issue such order, decree, or case decision, and any other information you wish to be considered with your application (i.e., information on the status of incarceration, parole, or probation, reference letters documentation of rehabilitation, etc.).	**YES** ☐	**NO** ☐
Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients or clients? If yes, please provide a full explanation. Note: The Board may ask for additional documentation.	**YES** ☐	**NO** ☐

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Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation? If no, please provide a full explanation. Note: The Board may ask for additional documentation.	**YES** ☐	**NO** ☐
Within the past five years have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? Please provide a full explanation on a separate page.	**YES** ☐	**NO** ☐
Within the past 5 years, have you been disciplined by any entity? Please provide a full explanation and any associated orders or letter from the entity.	**YES** ☐	**NO** ☐
Within the past five years, have any conditions or restrictions been imposed on you or your practice to avoid disciplinary action by any entity? If yes, please provide a full explanation and any associated orders or letters from the entity. (Note: The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider providing this documentation with your application, or have the program send this documentation directly to the Board.)	**YES** ☐	**NO** ☐

AFFIDAVIT OF APPLICANT

I have carefully read all applicable laws and regulations related to the practice of optometry. I hereby agree to abide by and remain current with the applicable laws and regulations which are available on the Board's website.

I certify by entering my signature below: I am the person applying for licensure/certification/registration and meet the qualifications required by Virginia law and regulations. Further, I certify the information provided in this application has been personally provided and reviewed by me, and that statements made on the application are true and complete. I understand that providing false or misleading information, as well as omitting information, in response to information requested in this application or as part of the application process are considered falsification of the application and may be grounds for denial of or taking disciplinary action against an existing license/certificate/registration.

_____
Signature of Applicant