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) 527-4471
Website: https://www.dhp.virginia.gov/Boards/Optometry/

BOARD OF OPTOMETRY

INSTRUCTIONS/CHECKLIST FOR REACTIVATION OF AN INACTIVE LICENSE

READ THE FOLLOWING INFORMATION CAREFULLY BEFORE PROCEEDING

- **Laws and Regulations**: Application requires an attestation to having read the applicable laws and regulations.

- **Application processing and documentation**: Applicant is responsible for notifying the source of the required documents to submit information directly to the board office by email, fax or postal mail. Optional forms for licensure verification and employment are available for review. Any faxed document requires a coversheet. Please allow 21 business days from initial mailing for board staff to receive and process an application. An initial email will be forwarded that provides a list of any missing application documentation.

- **Application and Fee:** Application and fee must be submitted together by postal mail. An application fee of **$100.00** for TPA-Certified Optometrist or **$50.00** for Non-TPA-Certified Optometrist; 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 reactivated.

- **Board Communication:** The Board's method of communication with applicants is via email.

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

- Complete Continuing Education (CE) Reporting Form **and** submit documentation of obtained CE (copies of completed certificates) in compliance with *18VAC105-20-70* equal to the requirement for the number of years in which the license has been inactive, 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 licensure verification from the states that provide online primary source verification that includes disciplinary history.).

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APPLICATION FOR REACTIVATION OF AN OPTOMETRY LICENSURE

☐ **TPA-Certified Optometrist** ☐ **Non-TPA Optometrist**

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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1. Have you been actively engaged in the practice of optometry prior to seeking reactivation of licensure in Virginia?	**YES** ☐	**NO** ☐
2. Have you completed the continuing education requirements for the period in which the license was lapsed, not to exceed two years?	**YES** ☐	**NO** ☐

3. 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

4. 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)

QUESTIONS MUST BE ANSWERED. If any of the following questions (5-11) are answered **yes**, explain and substantiate with documentation. Letters must be submitted by your attorney regarding malpractice suits.

5. 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, to include convictions for driving under the influence (DUI) and excludes traffic violations? 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, etc.)	**YES** ☐	**NO** ☐
6. 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? (A) Please provide a full explanation (use separate paper). (B) Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? ☐ **Yes** ☐ **No**	**YES** ☐	**NO** ☐
7. Within the past five years, have you been disciplined by any entity? (A) Please provide a full explanation and any associated orders or letters from the entity (use separate paper). (B) Within the past five years, have you sought or been directed to seek treatment for your conduct or behavior? ☐ **Yes** ☐ **No**	**YES** ☐	**NO** ☐
8. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing optometrist. If yes, please provide a full explanation (use separate page). (**NOTE**: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.)	**YES** ☐	**NO** ☐

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9. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing optometrist. If yes, please provide a full explanation (use separate page). (**NOTE**: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.)	**YES** ☐	**NO** ☐
10. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? "Currently" means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing optometrist. If yes, please provide a full explanation (use separate page). (**NOTE**: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.)	**YES** ☐	**NO** ☐
11. Within the past five 5 years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? If yes, please provide a full explanation (use separate page). (**NOTE**: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider providing this documentation with your application, or have your provider send this documentation directly to the Board.)	**YES** ☐	**NO** ☐

12. AFFIDAVIT OF APPLICANT

I have carefully read the 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