852-103 (TPA) (2-03)
STATE BOARD OF OPTOMETRY
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-7155
www.dos.state.pa.us

O	E	T						
						A	P	P	L	

AMOUNT _____

DATE _____

APPLICATION FOR CERTIFICATION TO PRESCRIBE AND ADMINISTER PHARMACEUTICAL AGENTS FOR THERAPEUTIC PURPOSES - FOR EXISTING PA LICENSEES WITH AN "L" OR "P" LICENSE

CATEGORY APPLYING UNDER (CHECK ONE) – SEE OVER

( ) Category I ( ) Category II

APPLICATION FEE - $25.00 check or money order payable to the "Commonwealth of PA". Fees are non-refundable and non-transferable. Note: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason.

NAME: _____
Last First Middle Maiden

ADDRESS: _____
Street

_____
City State Zip

PA OPTOMETRY LICENSE NUMBER : **OE -** _____ **-** _____ SS#: _____

DAYTIME TELEPHONE NUMBER: (_____)_____

YOU MAY NOT PRESCRIBE THERAPEUTIC DRUGS UNTIL YOU HAVE RECEIVED YOUR CERTIFICATION FROM THE BOARD. YOU MAY NOT PRESCRIBE CONTROLLED SUBSTANCES UNTIL YOU HAVE OBTAINED A DEA LICENSE FROM THE FDA (PHONE: 1-888-393-8231)

CERTIFICATION OF REQUIRED INSURANCE/VERIFICATION

By my signature below, I verify that I have obtained and will maintain the minimum of $200,000/occurrence and $600,000/annual aggregate professional liability insurance. I further certify that I will notify the Board within 30 days of my failure to be covered by the required amount of insurance.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 (relating to unsworn falsification to authorities) and may result in the suspension or revocation of my license. I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 Pa. C.S. Section 4911.

_____ _____
APPLICANT'S SIGNATURE DATE

OVER

The Board may grant therapeutic certification to applicants who have either: (CATEGORY I) graduated from an accredited school of optometry and as a condition for graduation have successfully completed 100 hours in the prescription and administration of pharmaceutical agents and have passed a licensure examination that included the prescription and administration of pharmaceutical agents for therapeutic purposes or (CATEGORY II) completed a Board-approved course of a minimum of 100 hours in the prescription and administration of pharmaceutical agents for therapeutic purposes and have passed an examination on the prescription and administration of pharmaceutical agents for therapeutic purposes.

IF APPLYING UNDER CATEGORY I, PROVIDE THE FOLLOWING:

1. Indicate the name and date you graduated from optometry school:

   Name of optometry school:_____

   Graduation Date – Month:_____Day:_____Year:_____

   NOTE: PROOF OF GRADUATION, INCLUDING CERTIFICATION FROM THE SCHOOL THAT YOU COMPLETED 100 HOURS IN PHARMACEUTICAL AGENTS THAT WERE REQUIRED FOR GRADUATION, MUST BE SENT TO THE BOARD OFFICE DIRECTLY FROM THE SCHOOL.

2. Indicate the date you passed the National Board Examination in Optometry, WHICH INCLUDED the prescription and administration of pharmaceutical agents for therapeutic purposes:

   Month:_____Day:_____Year:_____

   NOTE: A PASSING SCORE REPORT MUST BE SENT TO THE BOARD OFFICE DIRECTLY FROM NATIONAL BOARDS.

IF APPLYING UNDER CATEGORY II, PROVIDE THE FOLLOWING:

1. Indicate the name of the school (or provider) and date you completed a Board-approved 100 hour course in the prescription and administration of pharmaceutical agents for therapeutic purposes:

   Name of optometry school (or provider):_____

   Date Completed – Month:_____Day:_____Year:_____

   NOTE: PROOF OF COMPLETION MUST BE SENT TO THE BOARD OFFICE DIRECTLY FROM THE SCHOOL (OR PROVIDER).

2. Indicate the date you passed the National Board of Examiners in Optometry examination, on the prescription and administration of pharmaceutical agents for therapeutic purposes: (The Treatment and Management of Ocular Diseases, **TMOD** examination.)

   Month:_____Day:_____Year_____

   NOTE: A PASSING TMOD SCORE REPORT MUST BE SENT TO THE BOARD OFFICE DIRECTLY FROM NATIONAL BOARDS.