

STATE BOARD OF OPTOMETRY

P.O. Box 2649  
Harrisburg, PA 17105-2649

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Courier Address:  
2601 North Third Street  
Harrisburg, PA 17110

**APPLICATION FOR CERTIFICATION TO TREAT GLAUCOMA  
(for licensees currently certified to prescribe and administer pharmaceutical  
agents for therapeutic purposes)**

**\*\*\*APPLICATION CHECKLIST\*\*\***

**ALL APPLICANTS ARE REQUIRED TO:**

(Check when completed)

1.  Complete pages 1, 2 and 3 of the application.
2.  Application Fee: \$25.00 check or money order made payable to "Commonwealth of PA."

**PLEASE NOTE THE FOLLOWING:**

- \* Application fees are not refundable.
  - \* A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.
3.  The Bureau of Professional and Occupational Affairs (BPOA), in conjunction with the Department of Human Services (DHS), is providing notice to all health-related licensees and funeral directors that are considered "mandatory reporters" under § 6311 of the Child Protective Services Law (CPSL) (23 P.S. § 6311), as amended, that EFFECTIVE JANUARY 1, 2015, all persons applying for issuance of an initial license shall be required to complete 3 hours of DHS-approved training in child abuse recognition and reporting requirements as a condition of licensure. Please review the Board website for further information on approved CE providers. Once you have completed a course, the approved provider will electronically submit your name, date of attendance, etc., to the Board. [Child Abuse Continuing Education Providers Information can be found here.](#)
  4.  If applying under Category II (see page 1 and 2), you must submit copies of certificates of attendance to evidence completion of 18 hours of Board-approved continuing education in glaucoma.
  5.  If you answered YES to any of the criminal/disciplinary action questions, please provide accurate details on separate 8 ½" x 11" sheets of paper and provide copies of court documents.
  6.  If any documentation submitted in connection with this application will be received in a name other than the name under which you are applying, you must submit a copy of the legal document(s) indicating the name change (i.e., marriage certificate, divorce decree which indicates the retaking of your maiden name; legal document indicating the retaking of a maiden name, or court order).

**\*\*\*IMPORTANT INFORMATION\*\*\***

YOU MAY NOT TREAT GLAUCOMA UNTIL YOU HAVE RECEIVED YOUR OFFICIAL CERTIFICATION FROM THE PENNSYLVANIA OPTOMETRY BOARD.

**PLEASE NOTE:** If a pending application is older than one year from the date submitted and the applicant wishes to continue the application process, the Board shall require the applicant to submit a new application including the required fee.

In order to complete the application process, many of the supporting documents associated with the application cannot be more than six months from the date of issuance. All background check documents cannot be older than 90 days from the date of issuance.

## STATE BOARD OF OPTOMETRY

### Mailing Address:

P.O. Box 2649  
Harrisburg, PA 17105-2649  
Telephone: (717) 783-7155  
E-Mail: st-optometry@pa.gov

### Courier Address (if using a mailing service that requires a street address):

2601 North Third Street  
Harrisburg, PA 17110  
Fax: (717) 787-7769

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## APPLICATION FOR CERTIFICATION TO TREAT GLAUCOMA (for licensees currently certified to prescribe and administer pharmaceutical agents for therapeutic purposes)

**Application Fee:** \$25.00 check or money order payable to the "Commonwealth of Pennsylvania." *Not refundable.* A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

**IT IS YOUR RESPONSIBILITY TO MAINTAIN A COPY OF THIS APPLICATION AND ALL DOCUMENTS SUBMITTED TO OR RECEIVED FROM THE BOARD FOR YOUR FUTURE REFERENCE.**

**ALL ENTRIES MUST BE LEGIBLE.**

1. Name _____ (Last) (First) (Middle)	
2. PA optometry license number: <u>OE</u> _____	
3. Address _____ (Street) _____ (City) (State) (Zip Code) <i>The address you provide is the address that will be associated with this application to which all correspondence will be mailed. Please note that licenses <b>will not be forwarded.</b></i>	
4. Telephone _____ Fax _____	
5. E-Mail Address _____	
6. Date of Birth _____	7. Social Security Number _____
8. Category applying under (check one). The Board may grant certification to treat glaucoma to therapeutically certified licensees who have either: <input type="checkbox"/> CATEGORY I – obtained therapeutic certification from the Board by having graduated from an accredited school of optometry and a condition for graduation was the successful completion of a minimum of 100 hours in the prescription and administration of pharmaceutical agents for therapeutic purposes and have passed the National Board of Examiners in Optometry (NBEO) examinations that included the prescription and administration of pharmaceutical agents for therapeutic purposes. <b>OR</b> <input type="checkbox"/> CATEGORY II – obtained therapeutic certification from the Board by having completed a Board-approved course of a minimum of 100 hours in the prescription and administration of pharmaceutical agents for therapeutic purposes, have passed the Treatment and Management of Ocular Diseases examination (TMOD examination), and, since December 16, 2002, have completed 18 hours of Board-approved continuing education in glaucoma.	

**If applying under Category I, provide the following:**

Name of optometry school \_\_\_\_\_ Graduation Date (month/day/year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Indicate the date you passed the NBEO examinations, WHICH INCLUDED the prescription and administration of pharmaceutical agents for therapeutic purposes: Month/Day/Year \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**If applying under Category II, provide the following:**

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) \_\_\_\_\_ Completion Date (month/day/year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Indicate the date you passed the TMOD examination: Month/Day/Year \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**NOTE: You must submit copies of certificates of attendance to evidence completion of 18 hours of Board-approved continuing education in glaucoma.**

		YES	NO
9.	Will any documentation submitted in connection with this application be received in a name other than the name under which you are applying? If you answered YES, please provide the name or names. Submit a copy of the legal document evidencing the name change (i.e., marriage certificate, divorce decree or court order). _____	<input type="checkbox"/>	<input type="checkbox"/>
10.	Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice ANY health-related profession in any state or jurisdiction? If you answered YES to the above question, please provide the profession and state or jurisdiction. Please do not abbreviate the profession. _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>If you answered YES to any of the following questions, provide complete details as well as copies of relevant documents to the Board office.</b>		YES	NO
11.	Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, include any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	<input type="checkbox"/>	<input type="checkbox"/>
15.	Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	<input type="checkbox"/>	<input type="checkbox"/>

<b><i>If you answered YES to any of the following questions, provide complete details as well as copies of relevant documents to the Board office.</i></b>		<b>YES</b>	<b>NO</b>
16.	Since your initial application or last renewal, whichever is later, have you engaged in or have you ever engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Since your initial application or last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	<input type="checkbox"/>	<input type="checkbox"/>
19.	Since your initial application or last renewal, whichever is later, have you had practice privileges denied, revoked, suspended or restricted by a hospital or any health care facility?	<input type="checkbox"/>	<input type="checkbox"/>
20.	Since your initial application or last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>CERTIFICATION OF REQUIRED INSURANCE AND VERIFICATION</u></b>			
By my signature below, I verify that I have obtained and will maintain the minimum of \$1,000,000/occurrence and \$3,000,000/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.			

NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa.C.S. § 4304.1(a). At the request of the Department of Human Services (DHS), the licensing boards must provide to DHS information prescribed by DHS about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.

**Applicant's Statement:**

I verify that this application 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 under 18 Pa.C.S. § 4911.

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. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

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Applicant's Signature

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Date