

Professional Credential Services, Inc.

P.O. Box 198689 - Nashville, TN 37219-8689
www.pcshq.com

Licensure Application
for the
**Commonwealth of Massachusetts Board of Registration of
Optometry**

The Commonwealth of Massachusetts Board of Registration for Optometry has authorized Professional Credential Services (PCS) to process its Optometry licensure applications. **Applicants for licensure in Optometry must submit all of their information directly to PCS.** The Massachusetts Board of Optometry is the final authority with respect to issuance of the license.

INSTRUCTIONS

All candidates must complete the licensure application, typewritten or neatly printed in blue or black ink. Include all components of the requested information, especially names and addresses of institutions. All documents must have original signatures. All questions on the application must be answered.

REQUEST FOR INFORMATION

Applicants may contact PCS to obtain information, ask questions about application processing, or receive status updates by telephone or e-mail.

Toll-free: (877) 887-9727

Local: (615) 880-4275

E-mail: maoptometry@pcshq.com

INITIAL LICENSURE

Candidates who have never received licensure in another state must apply by Initial Licensure. Candidates who have held Optometry licensure in another state, may still apply for initial licensure if they meet the Board's current requirements for licensure. Initial licensure, if you are eligible, is generally the most efficient way to obtain your license. PCS must receive the following to process your application:

- a. A completed *Application for Massachusetts Optometry License*, including a 2x2 passport type photo and any supporting documentation.
- b. A completed Criminal Offender Record Information Request Form.
- c. An official transcript from your college or university.
- d. An official transcript from an accredited school of Optometry. Official transcripts must include your graduation date and carry the official seal of the school. The transcript may be sent directly to PCS or may be included with the application in a school sealed envelope.
- e. A certified transcript indicating your passing scores sent directly from the National Board to PCS for Parts I, II, III, and TMOD. (NERCOATS not accepted after 1/1/97.)
- f. CORI (Criminal Offender Record Information) Form.
- g. Verification of licensure from all other states in which you have been licensed, indicating you are in good standing. This is necessary whether the license is current or expired. You will have to contact each state to request this document be sent directly to PCS on your behalf.
- h. Payment of **\$460.00** Payments may be made with a VISA, MasterCard, certified check or money order. Please make certified checks or money orders payable to PCS and include your SSN on the front of the payment. **Fees are non-refundable and non-transferable.**

LICENSURE BY RECIPROCITY

Candidates who are currently and have been continuously licensed in another state for at least three full years and who do not meet the requirements for initial licensure may apply by reciprocity. PCS must receive the following to process your application:

- a. A completed *Application for Massachusetts Optometry License*, including a 2x2 passport type photo and any supporting documentation.
- b. A completed Criminal Offender Record Information Request Form.
- c. An official transcript from your college or university.
- d. An official transcript from an accredited school of Optometry. Official transcripts must include your graduation date and carry the official seal of the school. The transcript may be sent directly to PCS or may be included with the application in a school-sealed envelope.

- e. CORI (Criminal Offender Record Information) Form.
- f. A certified transcript indicating your passing scores sent directly from the National Board to PCS for Parts I, II, III, and TMOD. (Part III should reflect a date after 1/1/97. NERCOATS was accepted before 1/1/97.)
- g. Verification of licensure from all other states in which you have been licensed, indicating you are in good standing. This is necessary whether the license is current or expired. You will have to contact each state to request this document be sent directly to PCS on your behalf. The candidate must ask the state(s) that the candidate is currently licensed in, if that state would accept a Massachusetts candidate as a reciprocal candidate. The Board in question will need to submit this information in a letter to PCS. This is required for the file to be complete.
- h. Payment of **\$460.00** Payments may be made with a VISA, MasterCard, certified check or money order. Please make certified checks or money orders payable to Professional Credential Services and include your SSN on the front of the payment. **Fees are non-refundable and non-transferable.**

MASSACHUSETTS JURISPRUDENCE EXAMINATION

All candidates are required to take the Massachusetts Jurisprudence exam. After you are determined eligible for the exam, PCS will issue an authorization to test (ATT) to you for the Jurisprudence exam.

The Massachusetts Jurisprudence exam is offered on a daily basis at PSI testing facilities located throughout the United States. The exam is one hour in length and contains 25 multiple-choice questions. The examination pertains to the Massachusetts General Laws and the Code of Massachusetts Regulations as they relate to the practice of Optometry in the Commonwealth.

You will receive the results of the Jurisprudence exam at the PSI test site upon completion of the exam. Failing examinees will be given re-scheduling information.

ADDITIONAL LICENSURE PROCEDURES

When all licensure requirements are met (the forms are properly filled out, all documents are received, and you have passed the Jurisprudence exam), you will receive notice of licensure and your licensure status will be posted on the Board's web site. The Board will mail the wallet license within 6 weeks of the web site posting.

If you are being initially licensed with TPA certification, you must submit a separate application with the MA Department of Public Health Drug Control Program in order to exercise your prescribing privileges. You may reach that office by telephone at 617-983-6700 or at <http://www.mass.gov/dph/dcp/dcp.htm>.

If you are applying for licensure by reciprocity and you are seeking DPA or TPA certification, please review the DPA/TPA explanation available on the web site of the Massachusetts Optometry Board at: http://www.mass.gov/dpl/boards/op/forms/dpa_and_tpacert.pdf.

Some license applications will require the attention of the Board. You will be notified by PCS if your application must be addressed in this forum.

MAIL COMPLETED APPLICATION MATERIALS TO:

Postal Address:
Professional Credential Services, Inc.
Attn: MA Optometry Coordinator
P.O. Box 198689
Nashville, TN 37219-8689

Overnight Courier Address:
Professional Credential Services, Inc.
Attn: MA Optometry Coordinator
25 Century Blvd, Suite 505
Nashville, TN 37214

Application for Massachusetts Optometry License

Type of Applicant: Initial Licensure \$460.00 Licensure by Reciprocity \$460.00

A. Biographical Information.
Provide your full name, date of birth, social security number, and mailing address. It is very important that this section be completed in full.

First Name Middle Initial Last Name Other (Maiden)

Print your name as it should appear on your license

Mailing Address and Contact Information

Street or PO Box

City State Zip Code

Telephone Number with Area Code Fax Number Email address

B. Education. Provide high school, undergraduate and graduate college or university information, major, degree, and date of graduation. Be sure to include College of Optometry. *Transcripts must be sent to PCS directly or included in school-sealed envelopes.*

High School	Location		Date of Graduation
Undergraduate College/University	Location	Major	Undergraduate Degree & Date of Graduation
Graduate College/University	Location	Major	Graduate Degree & Date of Graduation

C. Licensure in other jurisdictions. This section is applicable to persons who have ever been or currently are licensed to practice as an optometrist.

List all professional licenses/certifications you hold in the United States or any other country or foreign jurisdiction and the state/jurisdiction from which the license/certification was originally issued. Please make arrangements with each state to send verification of licensure status, either current or expired, directly to Professional Credential Services (PCS). It is the applicant's responsibility to notify the state and pay any fees required by another licensing state.

State	Profession/ License Number	Date Licensed	Current	Lapsed	Revoked/ Suspended	Probation

D. Disciplinary Questions. Answer each of the questions listed. **If you answer yes to any, please attach an explanation.** All questions must be answered.

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Has any disciplinary action been taken against you by a licensing/certification board located in the United States or any other country or foreign jurisdiction? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you the subject of pending disciplinary actions by a licensing/certification board located in the United States or any other country or foreign jurisdiction? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever voluntarily surrendered or resigned a professional license to a licensing/certification board in the United States or any other country or foreign jurisdiction? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever applied for and been denied a professional license in the United States or any other country or foreign jurisdiction? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been convicted of a felony or misdemeanor in the United States or any other country or foreign jurisdiction, other than a traffic violation for which a fine of less than \$100 was assessed? | <input type="checkbox"/> | <input type="checkbox"/> |

E. General Questions. Answer each of the questions listed. If you answer no to any, please attach an explanation.

- | | | |
|---|--------------------------|--------------------------|
| 1. Pursuant to M.G.L. Chapter 62c, Section 49A, I have filed all State returns and have paid all State taxes required under law. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Pursuant to M.G.L. c.119, s.51A and c.112, s.1A, I certify that I understand my obligation to report the abuse or neglect of children. | <input type="checkbox"/> | <input type="checkbox"/> |

F. Membership in Optometry Societies or Organizations. List any memberships currently held in optometry Societies or Organizations.

G. Certification of Pending Graduation. Students in their final semester of Optometry college may apply for licensure only if this section is completed by the Dean of their School of Optometry. The college seal must be affixed where indicated.

I, _____, as Dean of
Name of Dean

_____ located at
School of Optometry

_____ and at
Address

telephone number _____ certify that _____ will
Telephone Number with Area Code Name of Applicant

receive the degree of _____ on _____.
Degree Name Month / Day / Year

Signature of Dean

Affix School Seal Here

H. Special Accommodations. In accordance with the Americans with Disabilities Act, special accommodations will be provided at the examination site for applicants who qualify.

Check here if you require special accommodations at the examination site for a disability. Please attach official medical documentation from your health care provider describing your condition. You must also indicate the type of modifications needed.

I. **Affidavit.** By signing this application, the applicant attests that this section has been read and fully understood. The application must be signed by the applicant and in the presence of a Notary Public in order to be processed.

Please be sure to write your date of birth and Social Security Number in numbers 1 and 2.

By my signature below, I certify, under the pains and penalties of perjury, that:

1. I am the applicant named in this application and by date of birth is _____ MM ____ DD ____ YY
2. My Social Security Number issued by the US Social Security Administration _____ - _____ - _____ *
3. The information that I have provided pursuant to this application is truthful and accurate. I understand that the failure to provide accurate information may be grounds for the Massachusetts Board of Optometry to deny, suspend, or revoke a license to practice as an Optometrists, in accordance with Massachusetts law.
4. I shall abide by the rules and regulations of the Massachusetts Board of Optometry, as contained in Chapter 259 of the Code of Massachusetts Regulations.
5. Pursuant to M.G.L.c. 119, s. 51A, and M.G.L.c. 112, s.1A, I understand my obligation to report the abuse or neglect of children.
6. Pursuant to M.G.L.c 62C, s. 49A, I have filed all Massachusetts State income tax returns and paid all taxes required by law.
7. The Massachusetts Board of Optometry, Division of Professional Licensure, has been certified by the Criminal History Systems Board for access to all criminal case data. As an applicant for Optometrist license, I acknowledge a criminal record check may be conducted for any existing criminal case information and that it will not necessarily disqualify me from licensure
8. I understand that all fees are non-refundable and non-transferable.
9. I am aware that under Massachusetts law, optometrists can only work in licensed or licensed exempt facilities.

J. **Applicant Signature.** Applicant MUST sign in the presence of a Notary Public, and list date of birth.

Applicant's Signature (signed in the presence of a Notary Public) & Date of Birth (MM/DD/YYYY)

Pursuant to G.L. c. 62C, s. 47A, the Division of Registration is required to obtain your Social Security Number and forward it to the Department of Revenue. The Department of Revenue will use your Social Security Number to ascertain whether you are in compliance with the tax laws of the Commonwealth. Accordingly, no application will be PROCESSED without the inclusion of YOUR valid Social SECURITY NUMBER.

K. **Photo.** Applicant must attach a 2"x2" passport size photograph to the application. Photocopies or computer generated photographs **are not** accepted.



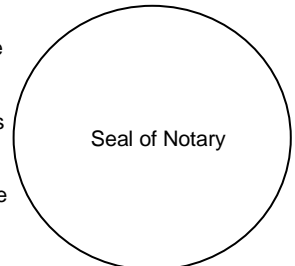
On _____
Month/Day/Year

Print Name of Notary Public

Signature of Notary Public

My Commission expires on _____
Date

On this _____ day of _____, 20_____, before me, the undersigned notary public, personally appeared _____ (Applicant's name), proved to me through satisfactory government issued evidence of identification, which was _____ (type of identification presented), to be the person who signed the preceding or attached document in my presence, and who swore or affirmed to me that the contents of the document are truthful and accurate to the best of (his) (her) knowledge and belief.



(Official signature)

(Name Notary)

**BOARD OF REGISTRATION OF OPTOMETRY
CRIMINAL OFFENDER RECORD INFORMATION (CORI)
ACKNOWLEDGEMENT FORM**

The Division of Professional Licensure by itself and on behalf of boards of registration pursuant to M.G.L. c. 13, §9 [hereinafter, "Division of Professional Licensure"] is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective license applicants and current licensees.

As a license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the Department of Criminal Justice Information Services ("DCJIS"). I hereby acknowledge and provide permission to the Division of Professional Licensure to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing the Division of Professional Licensure written notice of my intent to withdraw consent to a CORI check.

FOR LICENSING PURPOSES ONLY:

The Division of Professional Licensure may conduct subsequent CORI checks within one year of the date this Form was signed by me. If subsequent CORI checks are necessary, the Division of Professional Licensure will provide me with written notice of the subsequent CORI checks.

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

Signature

Date

Please provide the name of the board of registration and license type for which you are applying or currently hold:

Board of Registration

License Type

NOTE: THIS TWO-PAGE CORI ACKNOWLEDGMENT FORM WILL NOT BE ACCEPTED UNLESS IT HAS BEEN SIGNED IN THE PRESENCE OF A NOTARY PUBLIC WHO HAS COMPLETED THE "VERIFICATION BY NOTARY SECTION" ON PAGE TWO, DOCUMENTING THAT SAID NOTARY HAS VERIFIED THE IDENTITY OF THE SIGNER THROUGH SATISFACTORY EVIDENCE OF IDENTIFICATION.

SUBJECT INFORMATION: (A red asterisk (*) denotes a required field)

*Last Name *First Name Middle Name Suffix

*Maiden Name (or other name(s) by which you have been known)

*Date of Birth Place of Birth

*Last Six Digits of Your Social Security Number: _____ - _____

Sex: _____ Height: ____ ft. ____ in. Eye Color: _____

Driver's License or ID Number: _____ State of Issue: _____

Current and Former Addresses:

Street Number & Name City/Town State Zip

Street Number & Name City/Town State Zip

IDENTITY VERIFICATION SECTION: Prior to submission to the Board's application vendor, this Section must be completed.

VERIFICATION BY NOTARY:

On this _____ day of _____, 20____, before me, the undersigned notary public, personally appeared _____ (name of document signer), and proved to me through satisfactory evidence of identification, which was the following:¹

- Passport State-issued driver's license Military identification State-issued identification card

to be the person whose name is signed on the preceding or attached document, and acknowledged to me that (he) (she) signed it voluntarily for its stated purpose.

Notary Public:

Notary Commission Expires On _____

MassHealth Enrollment Requirement

Providers listed below must submit this form with your license application

Section 6401 of the Affordable Care Act requires that, for MassHealth services that must be ordered, referred or prescribed, the provider who ordered, referred or prescribed the service must be enrolled with MassHealth in order for the claim for the service to be payable.

The following provider types are eligible to order, refer or prescribe services for MassHealth members and, under state law, must apply to enroll with MassHealth at least as ordering and referring (nonbilling) providers in order to obtain and maintain state licensure. Providers who are already enrolled with MassHealth have already met the requirement and do not need to take further action.

Certified nurse midwife	Pharmacist (if authorized to prescribe)
Certified registered nurse anesthetist	Physician (including interns and residents)
Clinical nurse specialist	Physician assistant
Dentist	Podiatrist
Licensed independent clinical social worker	Psychiatric clinical nurse specialist
Nurse practitioner	Psychologist
Optometrist	

MassHealth has created a Nonbilling Provider Application for providers in provider types that are **not** eligible to enroll as fully participating providers. This application can also be used by providers who **are** eligible to enroll in MassHealth as fully participating providers but who choose not to at this time.

Providers who wish to apply to enroll as nonbilling providers must download the materials from the MassHealth website at <http://www.mass.gov/eohhs/provider/insurance/masshealth/aca/aca-section-6401enrollment-information.html> and send their completed and signed Nonbilling Provider Application and Nonbilling Provider Contract by mail to the MassHealth Customer Service Center (CSC) at:

MassHealth Customer Service Center
Attn: Provider Enrollment and Credentialing
PO Box 121205
Boston, MA 02112-1205

Dentists must submit their materials to:

MassHealth Dental Program
Attn: Provider Enrollment and Credentialing
P.O. Box 2906
Milwaukee, WI 53201-2906

Providers who enroll with MassHealth as nonbilling providers via the Nonbilling Provider Application are not fully participating MassHealth providers and are not eligible to submit claims to MassHealth.

Providers who have questions, or, if eligible, would like to request a fully participating provider application should contact the MassHealth Customer Service Center at 1-800-841-2900 with any questions or, if eligible, to request a fully participating provider application.

You must complete this section and sign below in order for your license application/renewal to be processed

I am already enrolled with MassHealth as a fully participating provider or a nonbilling provider

OR

I have submitted a thoroughly completed fully participating or nonbilling provider application and signed provider contract to MassHealth

By signing this form, you are providing your consent for the Massachusetts Boards of Registration and, where relevant, their supervising state agencies and the Massachusetts Executive Office of Health and Human Services, and where relevant, its provider enrollment vendor, to obtain, read, copy, and share with each other information regarding your MassHealth application and enrollment status and Massachusetts licensure status.

I certify under the pains and penalties of perjury that the information on this form has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

By: _____ (Signature)

Name: _____ (Printed Legal Name of Provider)

NPI: _____

Primary Service Location Address: _____

Date: _____

Payment Form

Application for Massachusetts Optometry License

Three payment options are available: Certified Check, Money Order or Credit Card. If paying by Certified Check or Money Order, please make it payable to “PCS” for the total amount of the examination(s) you are applying to take. DO NOT staple your payment to this form.

Please check form of payment below:

- Certified Check
- Money Order
- Credit Card

Authorized payment amount: \$ _____ Please check one: Visa or MasterCard

Card Number: _____ - _____ - _____ - _____ Exp: ____ / ____

Print name as it appears on account: _____

Authorized Signature: _____

Return this payment form with Application/Scheduling Form.

Note: This document will be shredded after it has been processed