



## **Dispensing Optician Apprenticeship Application Packet**

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### **Important Social Security Number Information:**

If you have a Social Security Number, the law requires you to disclose it on your application for a professional or occupational license. [42 U.S.C. § 666\(a\)\(13\)](#); [RCW 26.23.150](#). It will be used under the state’s child support enforcement program to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. If you do not have a Social Security Number, you are still eligible to apply for and obtain a credential if you meet the requirements. Please see the [Declaration of No Social Security Number Form](#). Please call the Customer Service Center at 360-236-4700 if you have questions.

### **In order to process your request:**

**Mail your application with initial documentation and your check money order payable to:**

Department of Health  
P.O. Box 1099  
Olympia, WA 98507-1099

**Send other documents not sent or with initial application to:**

Dispensing Optician Credentialing  
P.O. Box 47877  
Olympia, WA 98504-7877

### **Contact us:**

360-236-4700

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email [civil.rights@doh.wa.gov](mailto:civil.rights@doh.wa.gov).

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## Application Instructions Checklist

**Important background check Information:** Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the required forms.

**Application Fee.** This fee is non-refundable. You can check the online [fee page](#) for current fees.

**Select if the following applies:**  
Spouse or Registered Domestic Partner of Military Personnel

**1. Demographic Information:**  
**Social Security Number:** You must list your social security number on your application. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. Please see the [Declaration of No Social Security Number Form](#). Please call the Customer Service Center at 360-236-4700 if you do not have one.

**National Provider Identifier Number (NPI):** The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

**Legal Name:** List your full name: first, middle, and last.

**Definition of legal name:** “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

**Birth date:** Provide the month, day, and year of your birth.

**Address:** List the address we should use to send any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See [WAC 246-12-310](#).

**Phone, Fax, and Cell Numbers:** Enter your phone, fax, and cell numbers, if you have them.

**Email:** Enter your email address, if you have one.

**Other Name(s):** Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

**2. Personal Data Questions:**

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- Another jurisdiction means any other country, state, federal territory, or military authority.

**3. Licensee’s Information:**

List the supervisor’s information including their name, license number, business name, telephone number, and address. Check the box that indicates their license.

**4. Licensee’s Statement:**

The licensed supervisor must complete, sign and date this section.

**5. Applicant’s Attestation:**

Required to be both signed and dated in order to process the application.

**For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:**

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse’s or registered domestic partner’s military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state’s declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

## **Additional Information**

The apprenticeship program is one of three methods used to gain eligibility to sit for the dispensing optician examination.

### **Can I work as an apprentice without being registered?**

No. You must be registered with the Secretary of the Department of Health prior to beginning work as an apprentice dispensing optician.

### **Who can be a supervisor?**

A supervisor can be a licensed dispensing optician, optometrist, or physician.

### **What is a “primary supervisor”?**

The primary supervisor is the licensed optician, optometrist, or physician who is registered as your supervisor with the Department of Health. Your primary supervisor is responsible for your performance and must provide at least a majority of your training and supervision.

### **What if my supervisor is not available to supervise me all of the time?**

If your primary supervisor is not available to provide supervision for you at the place of employment of the primary supervisor, you may be supervised by another qualified supervisor. No supervisor may have more than two apprentices in training under their direct supervision at any one time.

### **What do I do if my supervisor leaves?**

If your primary supervisor will no longer act as your primary supervisor for any reason, you may not continue to work or accumulate hours until you have submitted an application to the department to be registered under a different supervisor and that application is approved by the secretary.

### **What should my supervisor do?**

When the supervisor terminates the registration, the supervisor must contact the department and provide a training certification indicating the start and finish dates of the time you were registered to the supervisor. They must also provide the number of hours of apprenticeship training you completed during that time.

### **How many hours are required?**

To qualify to sit for the dispensing optician licensing examination, an apprentice must complete 6,000 hours of training in a minimum of three years, or a maximum of six years.

### **How long does the apprenticeship last?**

The apprenticeship is registered for six calendar years. The time period continues whether or not there is a current active registration.

## **Exemption:**

An individual can perform dispensing optician duties without a dispensing optician license or without being registered as an apprentice if they are employed and personally supervised by a licensed optometrist or physician. Hours earned in this way are not credited toward the 6,000 hours required to sit for the dispensing optician licensing examination.

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Date  
Stamp  
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Revenue 0260010000

## Dispensing Optician Apprenticeship Application

Please print clearly. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so may result in a delay in processing your application.

**Select if the following applies:**

Spouse or Registered Domestic Partner of Military Personnel  Supervisor Change

### 1. Demographic Information

<b>Social Security Number (SSN)</b> (If you do not have a SSN, see instructions)	<b>National Provider Identifier Number (NPI)</b> (Enter 10 digit number)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer Not to Answer <input type="checkbox"/> X
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Name	First	Middle	Last
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Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	County
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Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
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Email address

Mailing address if different from above address of record

City	State	Zip Code	County
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Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)?  Yes  No If yes, list name(s):

Will documents be received in another name?  Yes  No If yes, list name(s):

Completed High School  General Education Development (GED)

## 2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

**“Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.  
1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

**Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.**

**The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.**

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ....

**“Currently”** means within the past two years.

**“Chemical substances”** include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

4. Are you currently engaged in the illegal use of controlled substances?.....

**“Currently”** means within the past two years.

**Illegal use of controlled substances** is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

**Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.**

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ...

**Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.**

**If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.**

**To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.**

## 2. Personal Data Questions (cont.)

Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? .....
  - b. Diverted controlled substances or legend drugs? .....
  - c. Violated any drug law? .....
  - d. Prescribed controlled substances for yourself? .....
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? .....
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? .....
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? .....
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? .....
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? .....

## 3. Licensee's Information

Supervisor's Name		License Number
Business Name		Telephone Number
Business Address		
City	State	Zip Code

Licensed to Practice As:

- Physician    Optometrist    Dispensing Optician

## 4. Licensee's Statement

I, \_\_\_\_\_, certify that I am qualified to act as an apprentice  
Name of Licensee

dispensing optician supervisor and I have read and am familiar with Chapter [18.34 RCW](#) and Chapter [246-824 WAC](#) relating to the training and registration of apprentice dispensing opticians. I understand that direct supervision requires a supervisor to provide the majority of the training and be on the premises 80 percent of the time while the apprentice dispenses spectacles and 100 percent of the time while the apprentice adjusts and fits contact lenses. I will record the beginning and ending dates of supervision of this apprentice and maintain a record of total hours worked under my supervision. I understand that I may not have more than two apprentices under my supervision at any one time.

\_\_\_\_\_  
Licensee's Signature

\_\_\_\_\_  
Date

## 5. Applicant's Attestation

I, \_\_\_\_\_, declare under penalty of perjury under the laws of the state of  
(Print applicant name clearly)

Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated \_\_\_\_\_ in \_\_\_\_\_  
(mm/dd/yyyy) (city, state)

By: \_\_\_\_\_  
(Signature of applicant)



Dispensing Optician Credentialing  
PO Box 47877  
Olympia, WA 98504-7877  
360-236-4700

## Dispensing Optician Apprentice Training Certification

Note: Use this form to **document total apprenticeship training hours** when the apprenticeship supervision has terminated.

Please Print Clearly

Supervisor's Full Name \_\_\_\_\_  
Last First Middle Initial

Business Name \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_

Daytime Telephone Number \_\_\_\_\_ License Number \_\_\_\_\_

Licensed to practice as:  Physician  Optometrist  Dispensing Optician

I certify \_\_\_\_\_, has been under my direct supervision as an  
Apprentice's Name

Apprentice Dispensing Optician for the period:

beginning \_\_\_\_\_ and ending \_\_\_\_\_  
mm/dd/yyyy mm/dd/yyyy

and has accrued a total of \_\_\_\_\_ apprenticeship hours while under my supervision.

I, \_\_\_\_\_, certify I am the person identified above  
Print or Type Full Name of Direct Supervisor

as the supervisor and to the best of my knowledge and belief the statements made in this affidavit are true and correct.

Please remove this apprentice from my license.  Yes  No

Signature \_\_\_\_\_ Date \_\_\_\_\_

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## **RCW/WAC and Online Website Links**

### **RCW/WAC Links**

[Uniform Disciplinary Act, RCW 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

[Administrative Procedures and Requirements, WAC 246-12](#)

[Dispensing Optician Law, RCW 18.34](#)

[Dispensing Optician Rules, WAC 246-824](#)

### **Online**

[Dispensing Optician Program, Web page](#)