

FILED: FEBRUARY 11, 2026



KENTUCKY BOARD OF OPHTHALMIC DISPENSERS

PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING

P.O. Box 1360, Frankfort, Kentucky 40602

500 Mero Street Frankfort, Kentucky 40601 (Overnight Delivery Only)

Phone: (502) 782.8810 | Fax: (502) 564.4818 | Website: bod.ky.gov | Email: BOD@KY.GOV

APPLICATION FOR OPHTHALMIC DISPENSER LICENSE

APPLICANT INFORMATION

Last Name:	First Name:	Middle Initial:	Previous Name:
Mailing Address: Street	City:	State:	Zip Code:
Business Address: Street	City:	State:	Zip Code:
Telephone Number: ()	Email Address:	Birthdate:	SSN:

GENERAL QUESTIONS

1. Are you licensed as an Apprentice in the state of Kentucky? If "Yes", please provide the following: Sponsor's name: _____ Sponsor's license number: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Have you ever held a Kentucky Ophthalmic Dispenser License? If "Yes", license number: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Have you ever been refused a license as an ophthalmic dispenser in Kentucky or any other state? If "Yes", please explain in full with an attachment:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Is there currently a complaint pending against you in another state in which you hold a license? If yes, please explain in full with an attachment:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Have you ever had your license to practice ophthalmic dispensing revoked, restricted, or denied in any state or territory or been placed on probation or entered a voluntary surrender of your license? If yes, explain in full with an attachment specifying state, date, charge, and circumstances:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Have you ever been involved in a court action, civil or criminal? If yes, please explain in full with an attachment:	<input type="checkbox"/> YES	<input type="checkbox"/> NO

EMPLOYMENT HISTORY

Begin with your most recent job and accurately list the details of each job you have held relating to your professional experience.

Employer:	From:	To:
City:	State:	Zip Code:
Employer:	From:	To:
City:	State:	Zip Code:
Employer:	From:	To:
City:	State:	Zip Code:

EDUCATION HISTORY

1. What is your highest level of education?	<input type="checkbox"/> High School	<input type="checkbox"/> College	<input type="checkbox"/> Grad School
2. Have You taken any academic work relating to ophthalmic dispensing? If "Yes", please list and attach verification: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
3. Are you a graduate of any school of ophthalmic dispensing approved by the board? If "Yes", please list and attach verification: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

FILED: FEBRUARY 11, 2026



KENTUCKY BOARD OF OPHTHALMIC DISPENSERS

PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING

P.O. Box 1360, Frankfort, Kentucky 40602

500 Mero Street Frankfort, Kentucky 40601 (Overnight Delivery Only)

Phone: (502) 782.8810 | Fax: (502) 564.4818 | Website: bod.ky.gov | Email: BOD@KY.GOV

<p>4. Have you completed the Basic Exams requirements? If "Yes", please select the qualifying exam and attach certificates:</p> <p><input type="checkbox"/> NCSORB (National Commission of State Opticianry Regulatory Boards) Date of Exam: _____ Certificate Number: _____</p> <p><input type="checkbox"/> ABO Basic (American Board of Opticianry & National Contact Lens Examiners) Date of Exam: _____ Certificate Number: _____</p> <p><input type="checkbox"/> NCLE Basic (American Board of Opticianry & National Contact Lens Examiners) Date of Exam: _____ Certificate Number: _____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>5. Have you completed the Practical Exams requirements?</p> <p><input type="checkbox"/> NCSORB (National Commission of State Opticianry Regulatory Boards) Date of Exam: _____ Certificate Number: _____</p> <p><input type="checkbox"/> ABO Basic (American Board of Opticianry & National Contact Lens Examiners) Date of Exam: _____ Certificate Number: _____</p> <p><input type="checkbox"/> NCLE Basic (American Board of Opticianry & National Contact Lens Examiners) Date of Exam: _____ Certificate Number: _____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>6. Check the type of operation you are associated with:</p> <p><input type="checkbox"/> Ophthalmic Dispenser <input type="checkbox"/> Optometrist's Office</p> <p><input type="checkbox"/> Jeweler & Optician <input type="checkbox"/> Ophthalmologist's Office</p> <p><input type="checkbox"/> Wholesale Distributor <input type="checkbox"/> Other: _____</p>		
<p>7. Will you be the owner, manager, or employee of the company where you will be employed? _____</p>		
<p>8. Have you completed a two (2) year apprenticeship?</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

*****REQUIRED SUPPORTING MATERIAL:** Letter(s) of good standing must be forwarded from each state licensure board in which you hold or have ever held a license.

TO BE COMPLETED FOR TEMPORARY PERMIT ONLY:

- A. Why are you applying for a temporary ophthalmic dispensing permit?

- B. Describe the duties for which you are employed?

- C. Is your position temporary or permanent? _____

VERIFICATION

I, the applicant named above, do hereby certify under penalty of law, that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected, or my certification revoked by the Board. Furthermore, I agree to abide by the standards of practice and code of ethics approved by the Board.

Applicant's Signature (Required) :	Date:
Printed Name:	
Sponsor's Signature (if applicable) :	Date:
Printed Name:	



KENTUCKY BOARD OF OPHTHALMIC DISPENSERS

PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING

P.O. Box 1360, Frankfort, Kentucky 40602

500 Mero Street Frankfort, Kentucky 40601 (Overnight Delivery Only)

Phone: (502) 782.8810 | Fax: (502) 564.4818 | Website: bod.ky.gov | Email: BOD@KY.GOV

APPLICATION FOR APPRENTICE OPHTHALMIC DISPENSER LICENSE

APPLICANT INFORMATION

Last Name:	First Name:	Middle Initial:	Previous Name:
Mailing Address: Street	City:	State:	Zip Code:
Business Address: Street	City:	State:	Zip Code:
Telephone Number: ()	Email Address:	Birthdate:	SSN:

GENERAL QUESTIONS

A. Have you previously held an apprentice license in the state of Kentucky?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
B. Have you ever held a Kentucky Ophthalmic Dispenser License? If yes, License # _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
C. Have you ever held or do you currently hold an ophthalmic dispenser license from any other state? If yes, please indicate state(s) and attach copies of any license(s) _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
D. Have you ever been refused a license as an ophthalmic dispenser in Kentucky or another state? If yes, please explain in full with attachment.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
E. Is there currently a complaint pending against you in another state in which you hold a license? If yes, please explain in full with attachment.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
F. Have you ever had your license to practice ophthalmic dispensing revoked, restricted or denied in any state or territory or been placed on probation or entered into a voluntary surrender of your license? If yes, explain in full with attachment specifying state, date, charge, and circumstances.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
G. Have you ever been involved in a court action, civil or criminal? If yes, please explain in full with attachment.	<input type="checkbox"/> YES	<input type="checkbox"/> NO

EMPLOYMENT HISTORY

Begin with your most recent job and accurately list the details of each job you have held relating to your professional experience.

Employer:	From:	To:
City:	State:	Zip Code:
Employer:	From:	To:
City:	State:	Zip Code:
Employer:	From:	To:
City:	State:	Zip Code:

EDUCATION HISTORY

1. What is your highest level of education?	<input type="checkbox"/> High School	<input type="checkbox"/> College	<input type="checkbox"/> Grad School
2. Have you taken any academic work relating to ophthalmic dispensing? If "Yes", please list and attach verification: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
3. Are you a graduate of any school of ophthalmic dispensing approved by the board? If "Yes", please list and attach verification: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
4. Have you completed the Basic exams requirements? If "Yes", please select the qualifying exam and attach certificates: <input type="checkbox"/> NCSORB (National Commission of State Opticianry Regulatory Boards)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

FILED: FEBRUARY 11, 2026



KENTUCKY BOARD OF OPHTHALMIC DISPENSERS

PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING

P.O. Box 1360, Frankfort, Kentucky 40602

500 Mero Street Frankfort, Kentucky 40601 (Overnight Delivery Only)

Phone: (502) 782.8810 | Fax: (502) 564.4818 | Website: bod.ky.gov | Email: BOD@KY.GOV

Date of Exam: _____ Certificate Number: _____ <input type="checkbox"/> ABO Basic (American Board of Opticianry & National Contact Lens Examiners) Date of Exam: _____ Certificate Number: _____ <input type="checkbox"/> NCLE Basic (American Board of Opticianry & National Contact Lens Examiners) Date of Exam: _____ Certificate Number: _____		
5. Check the type of operation you are associated with: <input type="checkbox"/> Ophthalmic Dispenser <input type="checkbox"/> Optometrist's Office <input type="checkbox"/> Jeweler & Optician <input type="checkbox"/> Ophthalmologist's Office <input type="checkbox"/> Wholesale Distributor <input type="checkbox"/> Other: _____		
6. Please provide the name and address of firm, partnership, corporation, or individual by which you will be employed.		
7. Will you be the owner, manager, or employee of the company where you will be employed? _____ What is your position with the firm? _____ Length of Employment: _____		

SPONSOR INFORMATION

NOTE: AN OUTLINE OF THE TRAINING SCHEDULE AND AN OVERVIEW OF THE FACILITIES LOCATED AT THE ESTABLISHMENT SHALL BE PREPARED BY THE SPONSOR AND FILED WITH THE BOARD WITH THIS APPLICATION.

1. Please provide the name of the licensed individual under whom you will receive your training. Sponsor's Name: _____		
2. Is your sponsor the Owner <input type="checkbox"/> Manager <input type="checkbox"/> Employee <input type="checkbox"/> of the company where you are employed? <input type="checkbox"/> YES <input type="checkbox"/> NO		
3. Will you be working under the direct supervision of a licensed ophthalmic dispenser, optometrist, or Ophthalmologist? If "No", explain: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO

APPLICANT'S CERTIFICATION

I, the applicant named above, do hereby certify under penalty of law, that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected, or my certification revoked by the Board. Furthermore, I agree to abide by the standards of practice and code of ethics approved by the Board.

Applicant's Signature (Required) :	Date:
------------------------------------	-------

Printed Name: _____

SPONSOR'S CERTIFICATION

I, the sponsor of record for the above-named applicant for apprenticeship, do hereby certify under penalty of law, that the information contained herein is true, correct, and complete to the best of my knowledge and belief. Further, I accept full responsibility for training the above named in accordance with the requirements of KRS Chapter 326 and 201 KAR Chapter 13. If, for any reason, the condition of this supervisory relationship is terminated or changed, I will immediately notify the Board. Further, I do hereby certify that my Kentucky license is current and will be maintained throughout this period. **I further certify that the outline of the training schedule and an overview of the facilities located at the establishment where the apprentice will be trained has been prepared by me and is being filed with this application for apprenticeship.**

Sponsor's Signature (if applicable) :	Date:	License No:
---------------------------------------	-------	-------------

Business Address: _____

Are you currently sponsoring another apprentice? If "Yes", please list name(s): _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
--	---------------------------------	--------------------------------



KENTUCKY BOARD OF OPHTHALMIC DISPENSERS

PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING

P.O. Box 1360, Frankfort, Kentucky 40602

500 Mero Street Frankfort, Kentucky 40601 (Overnight Delivery Only)

Phone: (502) 782.8810 | Fax: (502) 564.4818 | Website: bod.ky.gov | Email: BOD@KY.GOV

APPLICATION FOR RENEWAL AS AN OPHTHALMIC DISPENSER

Your Ophthalmic Dispenser license expires annually on December 31. In accordance with KRS 326.080 and 201 KAR Chapter 13 governing this profession, you are required to renew your license each year with the submission of this form, a renewal fee of \$125.00 for an active license and \$35.00 for an inactive status, by check or money order made payable to the **Kentucky State Treasurer** and show evidence of the completion of six (6) hours of continuing education. **Incomplete forms will be returned.**

Your renewal form must be received by this office (postmarked) on or before December 31. If your renewal is received (postmarked) after December 31, you will be required to pay an additional \$35.00 late administrative processing fee. **There are no exceptions. Any license not renewed on or before the March 1 grace period will expire and practice as an Ophthalmic Dispenser must cease and desist until the license is reinstated.** Any form which must be returned due to incomplete or incorrect information will be subject to late administrative processing fees if not received in our office by the deadline stated above.

APPLICANT INFORMATION

- Requesting re-activation of Inactive license (Fee required, continuing education required)
- Requesting re-activation of Expired license (Fee required, continuing education required)

Last Name:	First Name:	Middle Initial:	Previous Name:
Mailing Address: Street	City:	State:	Zip Code:
Business Name:		Business Address:	
Telephone Number: ()	Email Address:	License Number:	

201 KAR 13:055. Section 2. Each ophthalmic dispenser licensee shall be required to complete a minimum of six (6) continuing education hours to renew his license on active status each year. Continuing education hours more than the number of required at the time of renewal of license shall not be applied to future requirements.

First-year licensees — If your license was issued AFTER August 1, continuing education is not required for the first renewal. Any license issued between January 1 and July 31 ARE required to have continuing education hours.

Documentation to support your continuing education hours is not to be submitted unless you are audited by the board.

Course Name & Number	Date(s) Mo/Day/Yr	Continuing Education Provider	Hours Earned

TOTAL NUMBER OF CE HOURS OBTAINED:



KENTUCKY BOARD OF OPHTHALMIC DISPENSERS

PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING

P.O. Box 1360, Frankfort, Kentucky 40602

500 Mero Street Frankfort, Kentucky 40601 (Overnight Delivery Only)

Phone: (502) 782.8810 | Fax: (502) 564.4818 | Website: bod.ky.gov | Email: BOD@KY.GOV

Please provide the following information if continuing education information is not provided or not complete.

- First year licensee. (No continuing education required if license was issued *AFTER* August 1.)
- Requesting termination. (No fee or continuing education required.)
- Requesting Inactive Status (Fee required and no continuing education required.)

Please provide the following information regarding sponsorship.

- I am not currently sponsoring an apprentice.
- I have agreed to sponsor and provide supervision to an apprentice(s) working on site with me. I have listed below the name(s) of the apprentice(s).

Apprentice #1 _____ License Number _____

Apprentice #2 _____ License Number _____

VERIFICATION

I, the licensee named in the above, do certify that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that it is my sole responsibility to notify the board immediately, in writing, of any changes in the above information.

Applicant's Signature (Required) :	Date:
------------------------------------	-------



KENTUCKY BOARD OF OPHTHALMIC DISPENSERS

PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING

P.O. Box 1360, Frankfort, Kentucky 40602

500 Mero Street Frankfort, Kentucky 40601 (Overnight Delivery Only)

Phone: (502) 782.8810 | Fax: (502) 564.4818 | Website: bod.ky.gov | Email: BOD@KY.GOV

APPLICATION FOR RENEWAL AS AN APPRENTICE

Your Apprentice Ophthalmic Dispenser license expires annually on December 31. In accordance with KRS 326.080 and 201 KAR Chapter 13 governing this profession, you are required to renew your license each year with the submission of this form, a renewal fee of \$100.00 for an active license and \$35 for an inactive license, by check or money order made payable to the **Kentucky State Treasurer** and show evidence of the completion of four (4) hours of continuing education. **Incomplete forms will be returned.**

Your renewal form must be received by this office (postmarked) on or before December 31. If your renewal is received (postmarked) after December 31, you will be required to pay an additional \$35.00 late administrative processing fee. **There are no exceptions. Any license not renewed on or before the March 1 grace period will expire and practice as an Apprentice Ophthalmic Dispenser must cease and desist until the license is reinstated.** Any form, which must be returned due to incomplete or incorrect information, will be subject to late administrative processing fees if not received in our office by the deadline stated above.

APPLICANT INFORMATION

Requesting re-activation of Inactive license (Fee required, continuing education required)

Last Name:		First Name:		Middle Initial:	Previous Name:
Mailing Address: Street		City:		State:	Zip Code:
Business Name:			Business Address:		
Telephone Number: ()		Email Address:		License Number:	

<p>1. Have you completed the Basic Exams requirements? If "Yes", please select the qualifying exam and attach certificates:</p> <p><input type="checkbox"/> NCSORB (National Commission of State Opticianry Regulatory Boards) Date of Exam: _____ Certificate Number: _____</p> <p><input type="checkbox"/> ABO Basic (American Board of Opticianry & National Contact Lens Examiners) Date of Exam: _____ Certificate Number: _____</p> <p><input type="checkbox"/> NCLE Basic (American Board of Opticianry & National Contact Lens Examiners) Date of Exam: _____ Certificate Number: _____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>2. Have you completed the Kentucky Practical Exams requirements?</p> <p><input type="checkbox"/> NCSORB (National Commission of State Opticianry Regulatory Boards) Date of Exam: _____ Certificate Number: _____</p> <p><input type="checkbox"/> ABO Basic (American Board of Opticianry & National Contact Lens Examiners) Date of Exam: _____ Certificate Number: _____</p> <p><input type="checkbox"/> NCLE Basic (American Board of Opticianry & National Contact Lens Examiners) Date of Exam: _____ Certificate Number: _____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

201 KAR 13:055 Section 2. Continuing education hours more than the number required at the time of renewal of license shall not be applied to future requirements.

List below all continuing education information requested. Documentation to support your continuing education hours is not to be submitted unless you are audited by the board.



KENTUCKY BOARD OF OPHTHALMIC DISPENSERS

PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING

P.O. Box 1360, Frankfort, Kentucky 40602

500 Mero Street Frankfort, Kentucky 40601 (Overnight Delivery Only)

Phone: (502) 782.8810 | Fax: (502) 564.4818 | Website: bod.ky.gov | Email: BOD@KY.GOV

Documentation to support your continuing education hours is not to be submitted unless you are audited by the board.

Course Name & Number	Date(s) Mo/Day/Yr	Continuing Education Provider	Hours Earned
TOTAL NUMBER OF CE HOURS OBTAINED:			

Please provide the following information if continuing education information is not provided or not complete.

- First year license issued after August 1. (No continuing education required if license was issued *AFTER* August 1.)
- Requesting termination. (No fee or continuing education required.)
- Requesting Inactive Status (fee required and no continuing education required.)

I, the licensee named in the above, do certify that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that it is my sole responsibility to notify the board immediately, in writing, of any changes in the above information.

VERIFICATION

I, the licensee named in the above, do certify that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that it is my sole responsibility to notify the board immediately, in writing, of any changes in the above information.

Applicant's Signature (Required) :	Date:
------------------------------------	-------

I hereby certify that I do/will provide supervision as required by KRS 326.035(1) and as established in 201 KAR 13:050, Section 2(3) for the above licensed apprentice. I further agree to accept responsibility for his/her practice and activities in his/her capacity as an apprentice ophthalmic dispenser.

Sponsor's Signature (Required) :	Date:
----------------------------------	-------



KENTUCKY BOARD OF OPHTHALMIC DISPENSERS

PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING

P.O. Box 1360, Frankfort, Kentucky 40602

500 Mero Street Frankfort, Kentucky 40601 (Overnight Delivery Only)

Phone: (502) 782.8810 | Fax: (502) 564.4818 | Website: bod.ky.gov | Email: BOD@KY.GOV

APPLICATION FOR REINSTATEMENT AS AN OPHTHALMIC DISPENSER

For reinstatement due to license expiration for failure to renew. In accordance with KRS Chapter 326:080 and regulations governing this profession, you are required to renew you license each year with the submission of a renewal form, a renewal fee, and show evidence of the completion of six (6) hours of continuing education. The grace period for renewal ends March 1. If your Ophthalmic Dispenser license expired on March 1, you may use this form for reinstatement. **To reinstate your expired ophthalmic dispensers license**, you must complete this form and submit it with the reinstatement fee of **\$460.00** by check or money order made payable to the **Kentucky State Treasurer**, include proof of six (6) continuing education hours and return it to the above address. This amount includes the \$125 renewal fee, \$35 late fee, and \$300 reinstatement fee.

For reinstatement from inactive status. In accordance with 201 KAR 13:040. Section 7. You may use this form to apply to the board to return to active status. **To reinstate your inactive ophthalmic dispensers license**, you must complete this form and submit it with a fee of **\$40.00** by check or money order made payable to the **Kentucky State Treasurer**, include evidence of six (6) continuing education hours and return it to the above address. **Incomplete forms will be returned.**

APPLICANT INFORMATION

- Requesting re-activation of Inactive license (Fee required, continuing education required)
- Requesting re-activation of Expired license (Fee required, continuing education required)

Last Name:	First Name:	Middle Initial:	Previous Name:
Mailing Address: Street	City:	State:	Zip Code:
Business Name:		Business Address:	
Telephone Number: ()	Email Address:	License Number:	

201 KAR 13:055 Section 2. Continuing education hours more than the number required at the time of renewal of license shall not be applied to future requirements.

List below all continuing education information requested. Documentation to support your continuing education hours is not to be submitted unless you are audited by the board.

Documentation to support your continuing education hours is not to be submitted unless you are audited by the board.

Course Name & Number	Date(s) Mo/Day/Yr	Continuing Education Provider	Hours Earned



KENTUCKY BOARD OF OPHTHALMIC DISPENSERS

PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING

P.O. Box 1360, Frankfort, Kentucky 40602

500 Mero Street Frankfort, Kentucky 40601 (Overnight Delivery Only)

Phone: (502) 782.8810 | Fax: (502) 564.4818 | Website: bod.ky.gov | Email: BOD@KY.GOV

TOTAL NUMBER OF CE HOURS OBTAINED:

Please provide the following information if continuing education information is not provided or not complete.

- First year license issued after August 1. (No continuing education required if license was issued *AFTER* August 1.)
- Requesting re-activation of license (currently on inactive status with the provision that the licensee shall receive the appropriate number of continuing education hours within six (6) months of the date on which the licensee returns to active status. (Fee required, no continuing education hours required.)

Please provide the following information regarding sponsorship.

- I am not sponsoring an apprentice currently.
- I have agreed to sponsor and provide supervision to an apprentice(s) working on site with me. I have listed below the name(s) of the apprentice(s).

Apprentice #1 _____ License Number _____

Apprentice #2 _____ License Number _____

VERIFICATION

I, the applicant named above, do hereby certify under penalty of law, that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected, or my certification revoked by the Board. Furthermore, I agree to abide by the standards of practice and code of ethics approved by the Board.

Applicant's Signature (Required) :	Date:
------------------------------------	-------



KENTUCKY BOARD OF OPHTHALMIC DISPENSERS

PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING

P.O. Box 1360, Frankfort, Kentucky 40602

500 Mero Street Frankfort, Kentucky 40601 (Overnight Delivery Only)

Phone: (502) 782.8810 | Fax: (502) 564.4818 | Website: bod.ky.gov | Email: BOD@KY.GOV

APPLICATION FOR REINSTATEMENT AS AN APPRENTICE

For reinstatement due to license expiration for failure to renew. In accordance with KRS Chapter 326:080 and regulations governing this profession, you are required to renew your license each year with the submission of a renewal form, a renewal fee, and show evidence of the completion of six (6) hours of continuing education. The grace period for renewal ends March 1. If your Ophthalmic Dispenser license expired on March 1, you may use this form for reinstatement. **To reinstate your expired apprentice ophthalmic dispensers license**, you must complete this form and submit it with the reinstatement fee of **\$195.00** by check or money order made payable to the **Kentucky State Treasurer**, include proof of four (4) continuing education hours and return it to the above address. This amount includes the \$100 renewal fee, thirty-five (\$35) late fee, and sixty (\$60) reinstatement fee.

For reinstatement from inactive status. In accordance with 201 KAR 13:040. Section 7. You may use this form to apply to the board to return to active status. **To reinstate your inactive apprentice ophthalmic dispensers license**, you must complete this form and submit it with a fee of fifteen (**\$15.00**) by check or money order made payable to the **Kentucky State Treasurer**, include evidence of four (4) continuing education hours and return it to the above address. **Incomplete forms will be returned.**

APPLICANT INFORMATION

- Requesting re-activation of Inactive license (Fee required, continuing education required)
- Requesting re-activation of Expired license (Fee required, continuing education required)

Last Name:	First Name:	Middle Initial:	Previous Name:
Mailing Address: Street	City:	State:	Zip Code:
Business Name:		Business Address:	
Telephone Number: ()	Email Address:	License Number:	

<p>1. Have you completed the Basic Exams requirements? If "Yes", please select the qualifying exam and attach certificates:</p> <p><input type="checkbox"/> NCSORB (National Commission of State Opticianry Regulatory Boards) Date of Exam: _____ Certificate Number: _____</p> <p><input type="checkbox"/> ABO Basic (American Board of Opticianry & National Contact Lens Examiners) Date of Exam: _____ Certificate Number: _____</p> <p><input type="checkbox"/> NCLE Basic (American Board of Opticianry & National Contact Lens Examiners) Date of Exam: _____ Certificate Number: _____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>2. Have you completed the Practical Exams requirements?</p> <p><input type="checkbox"/> NCSORB (National Commission of State Opticianry Regulatory Boards) Date of Exam: _____ Certificate Number: _____</p> <p><input type="checkbox"/> ABO Basic (American Board of Opticianry & National Contact Lens Examiners) Date of Exam: _____ Certificate Number: _____</p> <p><input type="checkbox"/> NCLE Basic (American Board of Opticianry & National Contact Lens Examiners) Date of Exam: _____ Certificate Number: _____</p>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Sponsor's Name :	License No:
------------------	-------------



KENTUCKY BOARD OF OPHTHALMIC DISPENSERS

PUBLIC PROTECTION CABINET – DEPARTMENT OF PROFESSIONAL LICENSING

P.O. Box 1360, Frankfort, Kentucky 40602

500 Mero Street Frankfort, Kentucky 40601 (Overnight Delivery Only)

Phone: (502) 782.8810 | Fax: (502) 564.4818 | Website: bod.ky.gov | Email: BOD@KY.GOV

Business Address:

Phone Number: ()

201 KAR 13:055 Section 2. Each apprentice ophthalmic dispenser licensee shall be required to complete a minimum of four (4) continuing education hours to renew his license each year. Continuing education hours more than the number of required at the time of renewal of license may not be applied to future requirements. A minimum of two (2) of the required four (4) continuing education hours for renewal of apprentice ophthalmic dispenser licensure shall be obtained through programs sponsored by entities listed in Section 4(1) of the administrative regulation. The remaining continuing education hours may be obtained through any of the sources listed in Section 4 of the administrative regulation.

Documentation to support your continuing education hours is not to be submitted unless you are audited by the board.

Course Name & Number	Date(s) Mo/Day/Yr	Continuing Education Provider	Hours Earned
TOTAL NUMBER OF CE HOURS OBTAINED:			

Please provide the following information if continuing education information is not provided or not complete.

- First year license issued after August 1. (No continuing education required if license was issued *AFTER* August 1.)
- Requesting re-activation of license (currently on inactive status with the provision that the licensee shall receive the appropriate number of continuing education hours within six (6) months of the date on which the licensee returns to active status. (Fee required, no continuing education hours required.)

VERIFICATION

I, the applicant named above, do hereby certify under penalty of law, that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected, or my certification revoked by the Board. Furthermore, I agree to abide by the standards of practice and code of ethics approved by the Board.

Applicant's Signature (Required) :	Date:
------------------------------------	-------

SPONSOR VERIFICATION. I hereby certify that I do/will provide supervision as required by KRS 326.035(1) and defined by 201 KAR 13:050, Section 2(3) for the above licensed apprentice. I further agree to accept responsibility for his/her practice and activities in his/her capacity as an apprentice ophthalmic dispenser.

Sponsor's Signature (if applicable) :	Date:
---------------------------------------	-------