Ophthalmic Dispensing Form 5

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
www.op.nysed.gov

Department Use Only

Application for Limited Permit

APPLICANT INSTRUCTIONS

1. After submitting an application for licensure as a ophthalmic dispenser in New York State, you may file an application for a limited permit to practice pending receipt of the license. A limited permit in Contact Lens Dispensing can only be issued simultaneous with the issuance of a limited permit in Ophthalmic Dispensing or to an applicant who is already licensed as an ophthalmic dispenser.
   - An ophthalmic dispenser permittee may practice only under the supervision of a New York State licensed, currently registered physician, optometrist or ophthalmic dispenser. The supervisor must be on-site.
   - A contact lens permittee may practice only under the supervision of a New York State licensed, currently registered physician, optometrist or ophthalmic dispenser certified in contact lens dispensing. The supervisor must be on-site.
2. When applying for a limited permit, it is your responsibility to ensure that your prospective supervisor fully completes the Certification of Supervision, Section II**.**
3. Complete Section I and forward the form to your employer. Be sure to sign and date item 9. Limited permits expire two years from the date of issue. You should be certain you are ready to begin practice when you apply for the limited permit.
4. Limited Permits are issued for two years and expire when the applicants who pass the exam receive their license or ten (10) days after applicants are notified that they were unsuccessful on the practical licensing examination. Limited permits can be renewed for one additional year if the applicant did not fail the exam or was not denied licensure. An additional fee of $35 is required for a renewal.
5. Submit this application with a check or money order for the required fee of $35 made payable to the New York State Education Department, to the Office of the Professions at the address at the end of this form. If you have not already done so, you must submit an Application for Licensure (Form 1) and the licensure fee with this form and the limited permit fee. The permit application cannot be approved until all required documents have been received and approved. **You may not begin practice until the limited permit is issued.**
6. If you change or add employers or supervisors after the permit is issued, you must obtain a new permit. You may obtain a new permit by completing, with your prospective employer, a new Form 5 and returning it to the Office of the Professions. A fee is not required for a new permit issued as a result of a change in employment.

OD PERMIT NO._____

ISSUED _____

EXPIRES 2 YEARS FROM DATE OF ISSUE

OD 1 YEAR RENEWAL

ISSUED _____

EXPIRES _____

CL PERMIT NO._____

ISSUED _____

EXPIRES 2 YEARS FROM DATE OF ISSUE

CL 1 YEAR RENEWAL

ISSUED _____

EXPIRES _____

Initials

SECTION I: APPLICANT INFORMATION

1 **Check what you are applying for:**

☐ **Ophthalmic Dispensing (Limited Permit)** | 55 | $35 | PR

☐ **Contact Lens Dispensing (Limited Permit)** | 54 | $35 | PR

2 **Social Security Number**
(Leave this blank if you do not have a U.S. Social Security Number)

3 **Birth Date** Month ___ Day ___ Year ___

4 **Print Name**

Last

First

Middle

5 **Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1

Line 2

Line 3

City

State Zip Code

Country/ Province

6 **Telephone/E-Mail Address**

Daytime Phone

Area Code Phone Number

E-Mail Address (Please print clearly)

7 **I am applying for:**

☐ Original permit

☐ Additional/change of supervisor (No fee required)

☐ Additional/change of employer (No fee required)

☐ Renewal

8 Name of employer: _____

9 I declare and affirm that the statements made in the foregoing application are true, complete and correct. Any false or misleading information in, or in connection with, my application may be cause for denial of permit and licensure and may result in criminal prosecution.

_____ _____

Signature of applicant *Date*

SECTION II: INSTRUCTIONS TO THE SUPERVISOR

1. By completing the information below, you are certifying that the permittee will be employed under the supervision of a physician, optometrist or ophthalmic dispenser who is licensed and currently registered to practice in New York State and that the employer agrees to abide by the conditions stipulated on the permit.
2. Unless revoked, a limited permit shall expire two years from the date of issuance. Please note that a limited permit will expire ten (10) days after the applicant receives notice that they were unsuccessful on the practical licensing examination. See instructions for further information.
3. If applicant requests more than one employer at the same time, a separate Form 5 must be completed by each supervisor.
4. The applicant may not practice until the limited permit is issued.

CERTIFICATION OF SUPERVISION - *(To Be Completed By Supervisor)*

1. Applicant's name: _____

2. Employer:

Name: _____
(Enter full name -- no initials)

Street: _____

City: _____ State: _____ Zip code: _____ - _____

Telephone: _____ Fax: _____ E-mail: _____

3. If practice site is <u>different</u> from employer address (item 2), provide that address:

Name: _____

Street: _____

City: _____ State: _____ Zip code: _____ - _____

Telephone: _____ Fax: _____ E-mail: _____

4. Direct supervision will be provided by:

Name of supervisor: _____
(Please print or type)

Profession of supervisor: ☐ Ophthalmic Dispensing ☐ Optometry ☐ Medicine

CERTIFICATION

I certify that the applicant named above will be employed under my supervision. I am licensed and currently registered in New York State and agree to abide by the conditions stipulated on the permit.

I declare and affirm that the statements made in the foregoing certification are true, complete and correct. Any false or misleading information in, or in connection with this certification may be cause for disciplinary action against my license.

Signature of supervisor _____ Date _____ / _____ / _____
mo. *day* *yr.*

N.Y. License No. _____

Employer or appointed designee: _____
(Please print or type)

Signature of employer: _____ Date: _____ / _____ / _____
mo. *day* *yr.*

Return Directly To: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, PO Box 22063, Albany, NY 12201.