

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

STATE OF NEW HAMPSHIRE

DIVISION OF HEALTH PROFESSIONS

Board of Optometry

121 South Fruit Street, Suite 301

Concord, N.H. 03301-2412

Telephone 603-271-2428 · Fax 603-271-6702

PETER DANLES
Executive Director

JOSEPH G. SHOEMAKER
Division Director



In order for you to receive consideration for reinstatement, it will be necessary for you to complete the following requirements:

1. Complete and return the enclosed application along with the \$200.00 fee.
2. Submit a copy of a certificate certifying completion of cardio-pulmonary resuscitation (CPR), level C for adult, child and infant life support.
3. Submit proof of completion of continuing education which meets the requirements of Opt 402.

When the above documentation is received in this office, it will be presented to the Board for their consideration of reinstatement at their next regularly scheduled meeting. The Board meets once a month.

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O.D. 30 DAY REINSTATEMENT APPLICATION

NAME: _____

HOME ADDRESS: _____

_____ PHONE: _____

PRESENT PLACE OF PRACTICE: _____

ADDRESS: _____

_____ PHONE: _____

BIRTHDATE: _____ PLACE OF BIRTH: _____

ARE YOU A U.S. CITIZEN? _____

ADDITIONAL REQUIREMENTS

CPR Certification: Proof of standard adult, child and infant CPR Certification from a recognized certifying body is required. A copy of the certificate is acceptable.

Continuing Education Requirements: Submit proof of completion of continuing education which meets the requirements of Opt 402.

Have you ever been refused a license to practice optometry by any licensing authority in any jurisdiction? YES _____ NO _____

If YES, please list the name of the licensing authority, the date of the denial and the reason for the denial.

Have you ever had a license to practice optometry suspended or revoked in any jurisdiction? YES _____ NO _____

If YES, please explain:

Have you ever been convicted of a felony or misdemeanor? YES _____ NO _____

If YES, please list the name of the court, the details of the offense, the date of conviction and the sentence imposed.

If granted a license to practice Optometry in the State of New Hampshire, do you agree to practice ethically and in compliance with the provisions of the Revised Statutes Annotated of the State of New Hampshire and with the Rules of the Board of Registration in Optometry? YES _____ NO _____

(CURRENT PHOTO)

I, _____, O.D.,
herewith apply for examination and
licensure to practice Optometry in
accordance with RSA 327 and the rules of
the NH Board of Registration in Optometry,
and hereby certify that I am the applicant
identified in this application and that all
statements are true and correct to the best
of my knowledge and belief, and that the
enclosed photograph is a true likeness of
myself.

Signature of Applicant

DATE

FEE: \$200.00 – CHECK MADE PAYABLE TO: TREASURER, STATE OF NEW HAMPSHIRE.

FOR BOARD USE ONLY

Application received _____, 20____. Fee Paid: \$ _____

Check Number _____

CONTINUING EDUCATION FORM

PLEASE PRINT

****PLEASE CHECK ONE:** _____ TPA/g _____ TPA _____ Non-TPA

NAME: _____

HOME ADDRESS: _____

PHONE: _____

Please list below all activities pursued for continuing education during the past calendar year. A minimum of 15 annual hours is required for non-TPA certified optometrists. 50 hours, including a minimum of 20 class I hours, is required every year for TPA certified optometrists. **NOTE:** Please attach attendance slips for Class I continuing education and an activity list (next page) for Class II continuing education.

TPA/g Optometrists - CLASS I CONTINUING EDUCATION

Required hours in glaucoma specific education: A minimum of 7 Class I hours shall be by participation in formal courses and 3 hours may be by independent study.

<u>DATE</u>	<u>TOPIC</u>	<u>SPONSORING ORGANIZATION</u>	<u>HOURS</u>

TOTAL _____

TPA and Non-TPA Optometrists - CLASS I CONTINUING EDUCATION

A minimum of 20 hours shall be by participation in formal courses and the remainder by independent study.

(CONTINUE ON BACK IF NEEDED)

TOTAL _____

TOTAL CLASS II HOURS FOR THE PAST CALENDAR YEAR _____

INDEPENDENT STUDY ACTIVITY LOG
New Hampshire Board of Registration in Optometry

Activity/Title: _____

Journal/Author: _____

Date Completed: _____ **Time required for completion:** _____ **hours.**

Summary of content: _____

Activity/Title: _____

Journal/Author: _____

Date Completed: _____ **Time required for completion:** _____ **hours.**

Summary of content: _____

Activity/Title: _____

Journal/Author: _____

Date Completed: _____ **Time required for completion:** _____ **hours.**

Summary of content: _____

Activity/Title: _____

Journal/Author: _____

Date Completed: _____ **Time required for completion:** _____ **hours.**

Summary of content: _____

Activity/Title: _____

Journal/Author: _____

Date Completed: _____ **Time required for completion:** _____ **hours.**

Summary of content: _____
