# GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES

**DEPARTMENT OF HEALTH**
**P.O. BOX 222995, CHRISTIANSTED, VI 00822-2995**

**VIRGIN ISLANDS**
**BOARD OF OPTOMETRICAL EXAMINERS** **TEL. (340)643-8992 (STX)**

Dear Applicant:

We have received your request for information concerning licensure to practice **Optometry** in the U.S. Virgin Islands.

Enclosed are an application and the requirements for licensure. Please fill out the application and submit with all necessary documents to the Board.

Your interest is appreciated. If we can be of further assistance, please feel free to contact us.

Sincerely,

*Deborah Richardson-Peter, MPA*
Dir. Office of Professional Licensure & Health Planning
For V.I. Board of Optometrical Examiners

Enclosure

## REQUIREMENTS FOR OPTOMETRICAL LICENSURE IN THE U.S. VIRGIN ISLANDS

Applications for licensure shall be sent to the VI Board of Optometrical Examiners, VI Department of Health at **P.O. BOX 222995, CHRISTIANSTED, VI 00822-2995**. The applicant shall comply with the following requirements:

1. Submit application on the form prescribed by and obtainable from the Secretary, Board of Optometrical Examiners.

2. Submit a recent and dated unmounted photograph of passport size of himself/herself, autographed in ink across the back.

3. Submit a chronological account of all time spent between the date of graduation from the school of optometry school and time of submitting this application.

4. Be a graduate of an Optometry Program accredited by the Accreditation Council on Optometric Education (ACOE). Copy of degree is required.

5. Be twenty-one years of age or older. Submit copy birth certificate or similar evidence as proof.

6. Two (2) current, original signed professional recommendation forms (from colleagues or licensed professionals familiar with your clinical skills).

7. All applicants must show official proof of passing the National Board of Optometric Examiners (NBEO) exam Parts I, II, III and TMOD sections.

8. Show current proof of Cardiopulmonary Resuscitation (CPR) certification for health care providers.

9. A candidate applying for licensure shall submit with his/her application the non-refundable fee of **$200.00** made payable to the Government of the Virgin Islands.

10. Is not addicted to intemperate use of alcoholic stimulants or narcotic drugs. A notarized Affidavit signed by applicant attesting to the above must be furnished.

11. Submit a current (dated within 6 months of VI application) National Practitioner Data Bank self-query.
    A. Visit https://www.npdb.hrsa.gov/ext/selfquery/sqhome.jsp and begin the process for the self-query. Follow all instructions given.
    B. After your self-query has been processed by the NPDB, they will send the self-query report directly to you.
    C. You must first open this report to make sure that the results were not rejected, and all information submitted is correct.
    D. Send all parts of the self-query report directly to our office with your application.
    E. For NPDB questions or assistance, call 800-767-6732 or email help@npdb.hrsa.gov.

**BOARD OF OPTOMETRICAL EXAMINERS FOR THE U.S. VIRGIN ISLANDS**

## APPLICATION FOR LICENSURE

Print Name _____ _____ _____ _____
*first* *middle* *last* *suffix*

Social Security # (last four digits):_____

E-Mail _____ Mobile Phone _____

Mailing Address_____City_____State _____Zip Code_____

Home Address_____City_____State_____Zip Code_____

Birth Date_____/_____/_____ Birthplace_____

Citizen of_____
(**If you were not born in the United States, your own original certificate of Citizenship or of Declaration of Intention or of Derivative Citizenship must be submitted. Document will be returned by certified mail).**

High School_____ Location_____

College _____ Location_____

Professional School_____ Location_____

Graduation Date:_____ Degree Received:_____

*If employed, give name and address of employer

Has any State rejected your application and/or revoked your professional license? (Yes or No) _____
(If "Yes" attach explanation)

Have you ever been convicted of any crime or unprofessional conduct? (Yes or No) _____
If "Yes" attach explanation)

*Complete the attached License Application Data Form.

**New Address _____

_____

_____

**PASTE PHOTOGRAPH SECURELY IN THIS SPACE**

**Write signature on light portion of photograph, not across features.**

**Date of photograph**

## AFFIDAVIT

**Note:** Any false or misleading information in or in connection with any application may be cause for debarment on the ground of lack of good moral character.

State of _____ )
) ss
County or City of_____)

The undersigned, being duly sworn deposes and says that he/she is the person who executed this application; that the statements herein contained are true in every respect; that he/she has never been convicted of a crime; that he/she has never been expelled from any professional society; that he/she has not suppressed any information that might affect this application; that he/she will conform to the ethical standards of conduct in his/her profession; and that he/she has read and understands this affidavit.
*A crime would include either a felony or a misdemeanor.

_____
**(Signature of Applicant)**

Sworn to before me this _____ day of_____20_____

_____ _____
**Notary Public** **Commissioner of Deeds**

_____
**My Commission Expires on**

## PERSONAL SIGNATURE OF PERSONS RECOMMENDING APPLICANT

This certifies that I have been personally acquainted with the applicant since the year(s) indicated opposite my name; that I believe him/her to be of a good moral character and worthy of licensure in the U.S. Virgin Islands; and that any reservations I may have about the applicant I agree to send by certified mail in a confidential letter to the Board of Optometrical Examiners of the U.S. Virgin Islands.

(Signatures are required by not fewer than three citizens unrelated to applicant who must be licensed in the profession for which an applicant wishes to be examined or who are members of the staff of the professional school.)

| **Please Print Name** | **Personal Signature** | **P.O. Box Address** (Including street & city | **Known Since** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Return Application to:** **V.I. Board of Optometrical Examiners**
**Department of Health**
**P.O. Box 222995**
**Christiansted, VI 00822-2995**

# VERIFICATION OF LICENSURE

**APPLICANT IS REQUIRED TO COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH HE/SHE ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE OPTOMETRY. IF NEEDED, YOU MAY MAKE ADDITIONAL COPIES OF THIS PAGE.**

To Whom It May Concern:

I am being considered for Optometry licensure in the Territory of the U.S. Virgin Islands. The V.I. Board of Optometrical Examiners requires that this form be completed by each state in which, I am now or have ever been licensed to practice my profession. Enclosed is my authorization for release of information. **Please forward this form directly to: VI Board of Optometrical Examiners, c/o Department of Health, P.O. Box 222995, Christiansted, VI 00822-2995**

_____
Applicant's Signature

Name: _____
Address: _____
_____

My License No. in your State: _____

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**THIS SECTION IS TO BE COMPLETED AND SIGNED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE VI BOARD OF OPTOMETRICAL EXAMINERS.**

State/Territory of: _____

Full Name of Licensee: _____

License No.:_____ Issuance Date: _____

Is license current and in good standing? If NO, furnish details. _____

_____

_____

Has any disciplinary action ever been taken against the above-named Optometrist?_____ If YES, furnish details.

_____

_____

_____

Comments, if any: _____

_____

_____

Signed:_____

**BOARD SEAL**

Title:_____

State Board:_____

Date: _____


## AUTHORIZATION FOR RELEASE OF INFORMATION

In order for the Virgin Islands Board of Optometrical Examiners to assess and verify my educational background and professional qualifications, I hereby authorize the Board to:

- Make inquiries concerning such information about me to my employers (past and present), institution(s) or organization(s), my references, all governmental agencies and instrumentalities (local, state, federal or foreign);

- authorize the release of such information and copies of related records and documents to the Virgin Islands Board of Optometrical Examiners;

- authorize the Board to disclose to such person, employers, institutions, organizations, references, governmental agencies and instrumentalities identifying and other information about me sufficient to enable the Board to make such inquiries;

- release from liability all those who provide information to the Virgin Islands Board of Optometrical Examiners in good faith and without malice in response to such inquiries.

_____ _____

Signature Date

_____

Print Name

Subscribed and sworn to before me this _____day of_____20_____

_____ _____

Notary Public My Commission Expires


**VIRGIN ISLANDS BOARD OF OPTOMETRICAL EXAMINERS**
**DEPARTMENT OF HEALTH**
**P.O. BOX 222995, CHRISTIANSTED, VI 00822-2995**

## NOTARIZED NON-ADDICTION AFFIDAVIT

*I, _____ am not addicted to the intemperate use of alcohol, illicit drugs,*
(first, middle, last, suffix)

*any prescription medications including controlled substances or any mind-altering substances that may alter or impair my judgement and ability to carry out the duties of the profession.*

**Affidavit -** NOTE: Any false or misleading information in or in connection with any application may be cause for debarment on the ground of lack of good moral character.

_____ _____
Signature Date

_____
Print Name

Subscribed and sworn to before me this ____ day of_____20____

_____
Notary Public

_____
My Commission Expires

**VI BOARD OF OPTOMETRICAL EXAMINERS**
*P.O. Box 222995, Christiansted, VI 00822-2995 Tel: 340-643-8992*

# PROFESSIONAL RECOMMENDATION

This form must be completed and mailed DIRECTLY to the VI Board of Optometrical Examiners at **P.O. Box 222995, Christiansted, VI 00822-2995**. VIBOE requires the completion of two (2) Professional Recommendation forms from Colleagues or Licensed Professionals who are familiar with your clinical skills and have personal knowledge of your character, personal reputation, background and professional ability. This form is ***confidential*** and ***required*** as part of the application for licensure. ***All*** elements in the section below ***must*** be completed. The lower half of the form may be used for narrative comment. This is my authorization to send this completed form and release all information in your files, favorable or otherwise directly to the VI Board of Optometrical Examiners.

Applicant's Name:_____ Profession _____

Applicant's Signature:_____ Date:_____

Address:_____City:_____ State:_____Zip Code: _____

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**ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING PROFESSIONAL**
**The information on this form is confidential, this is NOT a public document.**

1. **Date and type of service: _____ This individual served with me as _____**

**From_____ to _____ at_____**
**Month/Year Month/Year Location**

2. **Please indicate with check mark:**

| | Poor | Fair | Good | Superior |
|---|---|---|---|---|
| **Professional knowledge** | ❑ | ❑ | ❑ | ❑ |
| **Clinical judgement** | ❑ | ❑ | ❑ | ❑ |
| **Relationships with patients or clients** | ❑ | ❑ | ❑ | ❑ |
| **Ethical/Professional conduct** | ❑ | ❑ | ❑ | ❑ |
| **Ability to communicate** | ❑ | ❑ | ❑ | ❑ |
| **Clinical skills** | ❑ | ❑ | ❑ | ❑ |

3. **Recommendation (please indicate with a check mark):**
   - ❑ **Recommend highly without reservation**
   - ❑ **Recommend as qualified and competent**
   - ❑ **Recommend with some reservation (explain)**
   - ❑ **Concerns (explain)**

4. **Of particular value in evaluating the candidate is information regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate your comments. If more space is needed please attach.**

_____

_____

_____

5. **The above report is based on: (please indicate with a check mark)**

❑ **Close personal observation** ❑ **General impression** ❑ **A composite of evaluations** ❑ **Other**

**Print Name: _____ Title: _____ Phone: _____**

**Signature: _____ Date: _____ Email: _____**