



Mississippi State Board of Optometry



Please complete this entire form so that we may maintain an accurate database.

LICENSEE'S FULL NAME: _____

Email address: _____

In an attempt to ease the renewal deadline at the end of the calendar year and to aid in provider enrollment processing, the Mississippi Department of Medicaid is requesting that all Optometrists provide the State Board office with their **Mississippi Medicaid Provider #**: _____

This does not exempt you from your responsibility to notify Medicaid that you have renewed your Mississippi License.

PRIMARY OFFICE ADDRESS:

SECONDARY OFFICE ADDRESS:

Name of Practice: _____ Name of Practice: _____

P.O. Box/Drawer: _____ P.O. Box/Drawer: _____

Street Address: _____ Street Address: _____

City: _____ State: _____ City: _____ State: _____

Zip: _____ County: _____ Zip: _____ County: _____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

HOME ADDRESS:

P.O. Box/Drawer: _____

Street Address: _____

City: _____ State: _____

Zip: _____ County: _____

Phone: _____

Please put a \sqrt in the box next to the address above that you wish to use as your mailing address.

You must fully complete both sides of renewal form and sign it.

<OVER>

CERTIFICATION:

MS License #: _____ TPA #: _____ Initial License Date: _____

DPA Certified: Yes No **DEA#:** _____

Jurisdictions where you are now licensed: _____

Any disciplinary actions in the last two years, or now pending in any of these jurisdictions: _____

TYPE OF PRACTICE: (Please Mark One)

- Solo Professional Corporation Partnership
 Employed by Optometrist Employed by Ophthalmologist

FULL PARTNERSHIP OR P.A. NAME: _____

The Mississippi continuing education requirements are 20 hours annually:

- **A minimum of 10 hours must be on the treatment and management of eye disease.**
- **A minimum of 16 hours must be approved by COPE, taken at a national, regional or state conference, or taken at a school of optometry/teaching institution.**
- **A maximum of 4 credit hours may be obtained in the following categories: General, Practice Management, Correspondence or On-Line.**

LICENSE RENEWAL CHECKLIST:

Please send proof of current CPR certification.

I request an exemption from CPR certification because I am not DPA certified.

Please send proof of 20 hours of continuing education for 2012.

(If you were enrolled on Optometry school during any time in the 2012 calendar year, you are exempt from the continuing education requirements.)

You may enclose copies of certificates of attendance for CE hours that are not OE Tracker hours and/or print out your OE Tracker record from the ARBO website.

Please send the completed application for 2013 license renewal.

Please enclose the annual renewal fee in the amount of \$325.00.

I have read the Rules and Regulations of the Mississippi State Board of Optometry, and do, by signing this application, certify that my Optometric practice conforms to these rules.

SIGNATURE: _____ **DATE:** _____

RETURN BEFORE DECEMBER 31, 2012 TO:

**Mississippi State Board of Optometry
P.O. Box 12370
Jackson, MS 39236-2370**