



South Carolina Department of Labor, Licensing and Regulation

South Carolina Board of Examiners in Optometry

110 Centerview Dr. • Columbia • SC • 29210

P.O. Box 11329 • Columbia • SC 29211-1329

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www.llronline.com/POL/Optometry/



2017-2018 OPTOMETRY RENEWAL FORM

Name: \_\_\_\_\_

License # \_\_\_\_\_

Instructions

- 1. Renew online at https://renewals.llronline.com You must have your user ID and Password to renew online. - OR-
2. Answer all the questions on this renewal form. Sign the form. Incomplete forms will be returned.
3. Include renewal fee and make check payable to: SC Board of Examiners in Optometry. Return all parts of this form.
Mail completed renewal form and correct fee to:

SC LLR Board of Examiners in Optometry, PO Box 11329, Columbia, SC 29211-1329

- 4. If you have questions, visit the Board's webpage at www.llr.state.sc.us/pol/Optometry/.
5. Due Date: Postmarked on or before December 31, 2016. License will lapse if not renewed by February 1, 2017.
6. Continuing Education Required: 40 hours obtained since January 1, 2015.

The Board will conduct a random CE audit after February 1, 2017. If you are audited, you will be required to submit proof of CE at that time. DO NOT send CE to the Board office unless instructed to do so.

Fee Schedule

Biennial Renewal Fee: \$230.00. If you practice at multiple SC locations: \$230.00 per SC practice location

Late Fee: \$50.00 + renewal fee if postmarked after January 1, 2017 - January 31, 2017. On February 1, 2017, your license will lapse and must be reinstated by a reinstatement application.

Table with 3 columns: Home Address, Primary Practice Location, Mailing Address. Rows include Phone, Fax, E-Mail, and Congressional District.

Continuing Education

- 1. Have you completed the required number of CE hours for this license for the renewal period? [ ] Yes [ ] No

If you answer "Yes" to any of the following questions, attach a full written explanation along with a copy of the Order or other relevant documentation.

- 2. Since you last renewed your license, have you been involved in any pre-trial intervention program, been convicted, pled guilty, or pled nolo contendere...
3. Since you last renewed your license, have you had an application for a professional license, examination, certification or registration denied or refused...
4. Since you last renewed your license, have you developed or been treated for any disease or condition, physical, mental, or emotional...
5. Since you last renewed your license, have you been addicted to or used in excess any drug or chemical substance...
6. Since you last renewed your license, have you had any investigation, formal complaint, disciplinary action or consent order filed against you...
7. Since you last renewed your license, has your ability to prescribe controlled substances ever been surrendered, revoked, suspended, limited or restricted?

8. Has there been any change in the status of your lawful presence in the United States since initial licensure?  Yes  No

**South Carolina Practice Locations**

9. Do you have an additional practice location(s) that has not been registered by the Board?  Yes  No

If Yes, you will need to download a Branch Office Registration form from the Board's website and mail it with your renewal form.

Please list your SC practice location(s) below.

**Primary Practice Location**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Hrs Per Week: \_\_\_\_\_

**Primary Practice Setting - Mark only one.**

- |   |   |
|---|---|
| <input type="checkbox"/> 11  Hospital Non Fed General         | <input type="checkbox"/> 24  Hospital Non Fed Rehab               |
| <input type="checkbox"/> 13  Optometric Center/Clinic         | <input type="checkbox"/> 22  Federal Non Military Health Facility |
| <input type="checkbox"/> 12  Nursing Home/Other Institution   | <input type="checkbox"/> 33  University/College Other             |
| <input type="checkbox"/> 23  Hospital Non Fed Psychiatric     | <input type="checkbox"/> 36  Tec/Junior College                   |
| <input type="checkbox"/> 21  Federal Military Health Facility | <input type="checkbox"/> 48  Other Government                     |
| <input type="checkbox"/> 15  Private Office                   | <input type="checkbox"/> 71  Other, Specify _____                 |

**Second Practice Location**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Hrs Per Week: \_\_\_\_\_

**Second Practice Setting:**

- |   |   |
|---|---|
| <input type="checkbox"/> 11  Hospital Non Fed General         | <input type="checkbox"/> 24  Hospital Non Fed Rehab               |
| <input type="checkbox"/> 13  Optometric Center/Clinic         | <input type="checkbox"/> 22  Federal Non Military Health Facility |
| <input type="checkbox"/> 12  Nursing Home/Other Institution   | <input type="checkbox"/> 33  University/College Other             |
| <input type="checkbox"/> 23  Hospital Non Fed Psychiatric     | <input type="checkbox"/> 36  Tec/Junior College                   |
| <input type="checkbox"/> 21  Federal Military Health Facility | <input type="checkbox"/> 48  Other Government                     |
| <input type="checkbox"/> 15  Private Office                   | <input type="checkbox"/> 71  Other, Specify _____                 |

**Third Practice Location**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Hrs Per Week: \_\_\_\_\_

**Third Practice Setting:**

- |   |   |
|---|---|
| <input type="checkbox"/> 11  Hospital Non Fed General         | <input type="checkbox"/> 24  Hospital Non Fed Rehab               |
| <input type="checkbox"/> 13  Optometric Center/Clinic         | <input type="checkbox"/> 22  Federal Non Military Health Facility |
| <input type="checkbox"/> 12  Nursing Home/Other Institution   | <input type="checkbox"/> 33  University/College Other             |
| <input type="checkbox"/> 23  Hospital Non Fed Psychiatric     | <input type="checkbox"/> 36  Tec/Junior College                   |
| <input type="checkbox"/> 21  Federal Military Health Facility | <input type="checkbox"/> 48  Other Government                     |
| <input type="checkbox"/> 15  Private Office                   | <input type="checkbox"/> 71  Other, Specify _____                 |

**Fourth Practice Location**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Hrs Per Week: \_\_\_\_\_

**Fourth Practice Setting:**

- |   |   |
|---|---|
| <input type="checkbox"/> 11  Hospital Non Fed General         | <input type="checkbox"/> 24  Hospital Non Fed Rehab               |
| <input type="checkbox"/> 13  Optometric Center/Clinic         | <input type="checkbox"/> 22  Federal Non Military Health Facility |
| <input type="checkbox"/> 12  Nursing Home/Other Institution   | <input type="checkbox"/> 33  University/College Other             |
| <input type="checkbox"/> 23  Hospital Non Fed Psychiatric     | <input type="checkbox"/> 36  Tec/Junior College                   |
| <input type="checkbox"/> 21  Federal Military Health Facility | <input type="checkbox"/> 48  Other Government                     |
| <input type="checkbox"/> 15  Private Office                   | <input type="checkbox"/> 71  Other, Specify _____                 |

**Activity Status and Primary Form of Practice**

**10. Current Activity Status - Mark only one.**

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> 01  Currently Practicing Profession | <input type="checkbox"/> 02  Not Currently Practicing Profession | <input type="checkbox"/> 08  Retired |
| <input type="checkbox"/> 18  Out-of-State                    |  |                                      |

**11. Current Primary Form of Practice - Mark only one.**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> 11  Self Solo                | <input type="checkbox"/> 35  Federal Military                 | <input type="checkbox"/> 14  Self Group Multi Spec          |
| <input type="checkbox"/> 12  Partnership Practice     | <input type="checkbox"/> 21  Employed Individual Practitioner | <input type="checkbox"/> 23  Employed by Practitioner Group |
| <input type="checkbox"/> 25  Other Private Employer   | <input type="checkbox"/> 34  Federal Civilian                 |   |
| <input type="checkbox"/> 28  Non-Profit Health Agency | <input type="checkbox"/> 71  Other, Specify                   |   |

A returned check fee of up to \$30, or an amount specified by law, may be assessed on all returned funds.

I HEREBY swear/affirm I have read all questions on this renewal application and have answered truthfully, accurately, and completely. I hereby acknowledge that failure to answer these question truthfully, accurately and completely shall constitute cause for the initiation of disciplinary action against my South Carolina license.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**DISCLAIMER**

"South Carolina Law requires the agency collect personal information which is only disseminated as required by law. The South Carolina Freedom of Information Act ensures that the public has a right to access appropriate records and information possessed by a government agency. Therefore, some personal information on your renewal application and other documents on file, may be subject to public scrutiny or release. The Department collects and disseminates personal information in compliance with The South Carolina Freedom of Information Act, the South Carolina Family Privacy Protection Act, and other applicable privacy laws and regulations. Additionally, the Department shares certain information on the application with other governmental agencies for various governmental purposes, including research and statistical services. In order to better protect the information you provide, please provide the Department with the following information that may be released to the public upon request: a public mailing address, a public email address and a public telephone number."