FLORIDA BOARD OF OPTICIANRY
GENERAL BOARD MEETING

AGENDA

October 23, 2020 at 9:00 A.M. EST

Teleconference Meeting
Call-in #: 1 (888) 585-9008
Participation Code: 123-475-828

John B. Girdler III, Chair

Janet E. Hartman, Executive Director

Florida Board of Opticianry
General Board Meeting
October 23, 2020

BOARD MEMBERS:

John B. Girdler III, Chair
Paul Wilford, Vice-Chair
Irene Stavros, RDH
Richard Williams

BOARD STAFF:

Janet Hartman, Executive Director
Eric Pottschmidt, MBA, Program Operations Administrator

BOARD COUNSEL:

Timothy Frizzell, Assistant Attorney General

DEPARTMENT OF HEALTH COUNSEL

Rose Garrison, Esq., Assistant General Counsel
Zachary Bell, Assistant General Counsel

COURT REPORTER:
For the Record

Participants in this public meeting should be aware that these proceedings are being recorded. An audio file of the meeting will be posted on the Florida Board of Opticianry website.

AGENDA

TAB 1. CALL TO ORDER
- Roll Call

TAB 2. REVIEW AND APPROVAL OF MINUTES
- June 30, 2020
- August 3, 2020

TAB 3. DISCIPLINE
- VR-01 James A. Matthews, III., Apprentice Optician - Case Number 2019-04481

TAB 4. PROSECUTOR'S REPORT

TAB 5. REQUEST FOR EARLY TERMINATION OF PROBATION

- Minina McKie - DO 4049 Case- 2018-13101

TAB 6. APPLICATION REQUIRING REVIEW

- Wendi Adams – Apprentice Optician – File #5990 – Order to Appear

TAB 7. REPORTS

- Chair's Report – John B. Girdler, III
    - NCSORB Basic Exam
    - Continuing Education
    - MQA Annual Reports and Projections
    - 2021 Delegations

- Vice Chair's Report – Paul Wilford

- Executive Director's Report – Janet Hartman
    - Financial Report
    - New State Car Rental Agreement - Avis
    - 2021 Meeting Dates

- Board Counsel's Report – Timothy Frizzell

    - 64B12-9.001, F.A.C. - Examination for Licensure
    - 64B12-8.020, F.A.C. - Disciplinary Guidelines
    - 64B12-8.024, F.A.C. - Out-of-State Telehealth Discipline
    - Comprehensive Rule Review
    - ADA Case – Doe v. Ky Bar Association
    - Law360 SmileDirect
    - Annual Regulatory Plan
    - Rules Report

TAB 8. RATIFICATIONS

- Licenses Issued
- CE Broker Courses Approved

TAB 9. CE COURSES REQUIRING BOARD REVIEW

- CEDO, Inc. – Course #20-706479 - Anisometropia in the 21st Century
- CEDO, Inc. – Course #20-716031 - Can Nutrition Reverse Diabetes & its Causation of Eye Disease?
- Florida Optometric Association – Course # 20-779946 – Creating Your Practice of Distinction

- Focal Education, LLC. – Course #20-790716 - Lens Manufacturing, Past, Present and Future
- Focal Education, LLC. – Course #20-787204 – Modern Optical Laboratory Production
- Quantum Optical, Inc. – Course #20-790260 – Field Guide to Freeform

TAB 10. ELECTIONS

TAB 11. NEXT MEETING DATE – January 15, 2021 – Teleconference Meeting

TAB 12. OLD BUSINESS/NEW BUSINESS

TAB 13. PUBLIC COMMENTS

TAB 14. ADJOURNMENT

FLORIDA BOARD OF OPTICIANRY
EMERGENCY RULE MEETING
June 30, 2020 @ 5:30 P.M.
Telephone Conference Call
Dial-in #: 1 (888) 585-9008
Participation Code: 744-469-610

DRAFT MINUTES

The meeting was brought to order at 5:30 P.M. EST and roll call was conducted by Janet Hartman.

Members Present:
John B. Girdler, Chair
Paul Wilford, Vice-Chair
Richard Williams

Members Not Present:
Irene Stavros, RDH

Staff Present:
Janet Hartman, Executive Director
Eric Pottschmidt, Program Operations Administrator
Timothy Frizzell, Assistant Attorney General

Court Reporter:
For the Record
850-224-0728

Emergency Rule - Continuing Education Rule 64B12-15 (TS – 01:00 Minutes)
Timothy Frizzell reviewed history of issue, discussed proposed emergency rule, and opened floor to the Board members for discussion.

Paul Wilford commented on subject matter of what "live" means. **(TS – 04:30 Minutes)**

Timothy Frizzell responded to Paul Wilford's comments. **(TS – 09:00 Minutes)**

Wilbur Brewton representing Professional Opticians of Florida joined the discussion. **(TS – 17:25 Minutes)**

John Girdler responded to Wilbur Brewton's comments and continued discussion with Timothy Frizzell and Wilbur Brewton. **(TS – 22:20 Minutes)**

Janet Hartman reads language onto the record of the recommended competing emergency rule as presented by Professional Opticians of Florida and Wilbur Brewton **(TS – 29:10 Minutes)**

Richard Williams commented that he agreed with what was read into the record by Janet Hartman.

Public Comments (TS – 32:00 Minutes)

Janet Hartman opened floor to public comments:

Anthony Record presented his comments.
Carole Bratteig's letter read into record by Janet Hartman.
Laurie Pierce presented her comments.
Mr. August presented his comments.
Cory and Kimberly Sigouin with Focal Education presented their comments.
Rhonda Weiss presented her comments.

After no further discussion, the Board took the following action: **(TS – 53:15 Minutes)**

Motion: by Richard Williams to adopt language read into record by Janet Hartman.
Second: by Paul Wilford
Vote: Passed Unanimously

Timothy Frizzell asked required SERC question:

Should a violation of this rule or any part of this rule be designated as a minor violation?

Motion: by Richard Williams votes "NO"
Second: by John Girdler
Vote: Passes Unanimously

Adjournment (TS – 58:00 Minutes)

Motion: by Richard Williams to adjourn the meeting.
Second: Paul Wilford
Vote: Passes Unanimously

FLORIDA BOARD OF OPTICIANRY
GENERAL BOARD MEETING
June 30, 2020 @ 5:30 p.m.
Telephone Conference Call
Dial-in #: 1 (888) 585-9008
Participation Code: 744-469-610

DRAFT MINUTES

The meeting was brought to order at 6:30 P.M. EST and roll call was conducted by Janet Hartman.

Members Present:
John B. Girdler, Chair
Paul Wilford, Vice-Chair
Richard Williams

Members Not Present:
Irene Stavros, RDH

Staff Present:
Janet Hartman, Executive Director
Eric Pottschmidt, Program Operations Administrator
Timothy Frizzell, Assistant Attorney General

Court Reporter:
For the Record
850-224-0728

REVIEW AND APPROVAL OF MINUTES – April 24, 2020

Motion: by Richard Williams to approve April 24, 2020
Second: by Paul Wilford
Vote: Passed Unanimously

PROSECUTOR'S REPORT

There are currently nine open disciplinary cases in the PSU Detailed Inventory.

- Under Legal Review: 4
- Cases with probable cause recommendation: 1

- Probable cause found: 3
- Cases pending before DOAH: 0
- Cases agendaed for Board: 1
- Cases Older Than One Year: 4

Currently there are a total of nine active cases in the Department's Opticianry inventory. Of those cases, four are year and older cases and three of those cases have had a finding of probable cause. As always, the Department's prosecutors are working diligently to timely resolve all outstanding cases, and we are very close to doing so.

Motion: by Richard Williams to allow PSU to continue to prosecute one year and older cases.
Second: by Paul Wilford.
Vote: Passed Unanimously

APPLICATION REQUIRING REVIEW

Wendi Adams – Apprentice Optician – File #5990 – Order to Appear
Wendi Adams was not present and did not have legal representation.
Moved to next Board meeting due to personal complications and through prior communication with the Board Office, has suggested she may be withdrawing her application for later consideration.

MARITZA SILIO CORRESPONDENCE (TS – 1:04:00 Minutes)

Maritza Adams was not present for presentation of her letter. Timothy Frizzell provided summary of letter and concluded that her issue may have been resolved with the passing of the emergency rule in the previous meeting. Program Operations Administrator Eric Pottschmidt will contact Mrs. Silio to update her on rule changes.

REPORTS

Chair's Report – John B. Girdler – Nothing to report.

Vice Chair's Report – Paul Wilford – Nothing to report.

Executive Director's Report – Janet Hartman **(TS – 1:05:45 Minutes)**
National Commission of State Opticianry Regulatory Board's Examinations – Psychometrician Evaluation Report

Alex Bosque presented the findings of the report.

Alex Bosque was asked to review the written examinations developed by National Commission of State Opticianry Regulatory Board (NCSROB). The report looked at how the exam was developed, the length of time the exams were used, if its being used by any state boards or associations, and conducted two job task analysis (In 2012 and in 2018). A third job task analysis was conducted to determine examination format and content to make sure it is consistent with the findings of their job task analysis and that the exams have a valid reliability measure. It also looked at how the exam is administered and the security perimeters, and ensured it provided adequately per acceptable standards. The overall conclusion is that they have a valid, reliable examination.

Wade Delk joined the discussion. John Girdler asked if the practical examination in Florida will have any substantive changes. Wade Delk answered, no.

Wade Delk opened the floor to the Board members for questions. John Girdler asked Wade Delk to add pass rates to the report.

John Girdler would like to ask for a vote to accept the report at the next board meeting.

Timothy Frizzell will create appropriate rule language so the Board may move forward upon review at the next board meeting.

Jim Morris joined the meeting to provide American Board of Opticianry (ABO) and National Contact Lens Examiners (NCLE) updates. **(TS – 1:14:00 Minutes)**

Paper Application Update **(TS – 1:20:10 Minutes)**

Janet Hartman reviewed Health History Questions and Student Loan Default Questions.

DH-MQA 1065, 6/2020 - Optician Application for Examination
DH-MQA 1180, 6/2020 - Apprentice Application for Registration

After discussion, the following action was taken:

Motion: by Richard Williams to approve all applications as written.
Second: by Paul Wilford
Vote: Passed Unanimously

Board Counsel's Report – Timothy Frizzell
Rule 64B12-16.003 – Apprentice Application
Rule 64B12- 9.0015 - Optician Application for Examination

After discussion, the following action was taken:

Motion: by Paul Wilford to approve the rule language as written for both applications.
Second: by Richard Williams
Vote: Passed Unanimously

Will the proposed rule amendments have adverse impact on small business?

John Girdler stated "NO"
Paul Wilford stated "NO"
Richard Williams stated "NO"

Will the proposed rule amendments be likely to directly or indirectly increase regulatory costs to any entity including government in excess of $200,000 in the aggregate in Florida within one year after implementation?

John Girdler stated "NO"
Paul Wilford stated "NO"
Richard Williams stated "NO"

Should a violation of this rule or any part of this rule be designated as a minor violation?

John Girdler stated "NO"
Paul Wilford stated "NO"
Richard Williams stated "NO"

Rule Development **- (TS – 1:27:45 Minutes)**

Timothy Frizzell discusses proposed rule changes as a result of a letter received from the Joint Administrative Procedures Committee (JAPC), housekeeping changes made and recommended by the Chair, and items directly related to the COVID-19 situation and distance learning, and makes recommendations to the Board of what proposed rule changes to pass.

Janet Hartman referenced letter from Brewton Plante, P.A.

John Girdler opened the floor for discussion.

Public Comments **(TS – 1:35:00 Minutes)**
Anthony Record presented his comments.
Laurie Pierce presented her comments.
Glenn with Professional Opticians of Florida presented his comments.
Vince Catonni from Jacksonville presented his comments.

After discussion, the Board decided to postpone a vote on the current proposed rule language changes and convene a future meeting to clarify and better define the proposed rule language changes.

Rules Report **–** no discussion.

Annual Regulatory Report
Motion: by Richard William to allow the Chair to work with board counsel and sign-off on the Annual Regulatory Plan to be presented at the next board meeting after October for ratification.
Second: by Paul Wilford
Vote: Passed Unanimously

RATIFICATIONS

Licenses Issued

Motion: by Richard Williams to accept the ratification list for 2001, 2002, and the CE Broker approved courses.
Second: by Paul Wilford
Passed: Unanimously

NEXT MEETING DATE – TBD – October 23, 2020 Meeting Cancelled at the Westin Fort Lauderdale Beach Resort due to COVID-19. Will look to convene another meeting in the Fall in an alternate location further north.

PUBLIC COMMENTS (TS – 1:49:45 Minutes)

Glenn with Professional Opticians of Florida asked if a test may be added to live courses already submitted and approved, or do the courses have to be resubmitted in their entirety? Board Counsel responded that the tests would be required to be submitted for the CE Committee to review.

Laurie Pierce presented her comments and asked for clarification of the test requirement question presented by Glenn from Professional Opticians of Florida (POF). Board Counsel responded that all materials would need to be resubmitted.

Vince Catonni from Jacksonville presented his comments.

John Girdler requested that the Board re-read all the proposed language changes prior to the next meeting.

ADJOURNMENT

Motion: by Richard Williams to adjourn the meeting.
Second: by Paul Wilford
Passed: Unanimously

FLORIDA BOARD OF OPTICIANRY
GENERAL BUSINESS MEETING
August 3, 2020 @ 5:30 P.M.
Telephone Conference Call
Dial-in #: 1 (888) 585-9008
Participation Code: 744-469-610

DRAFT MINUTES

Meeting was called to order @ 5:32 P.M. EST

Roll call conducted by Janet Hart

Members Present:

John B. Girdler, Chair
Paul Wilford, Vice-Chair
Irene Stavros, RDH
Richard Williams

Staff Present:

Janet Hartman, Executive Director
Eric Pottschmidt, Program Operations Administrator
Timothy Frizzell, Assistant Attorney General

Court Reporter:
For the Record
850-224-0728

AGENDA

Continuing Education Discussion - Chapter 64B12-15, F.A.C. and 64B12-15.001, F.A.C. – Alternative Proposal (TS – 01:15 Minutes)

John Girdler presented opening comments and inquired if the Board had any questions regarding the rule changes.

Richard Williams made comment that he is against making any changes to the rules without a full board. He further commented that if the rule changes were to extend existing rules for another 90 days, he would agree to that, but he would not agree to any other rule changes.

Janet Hartman announced there were two proposals being presented. One with five pages of various rule changes to encompass Chapter 64B12-15, F.A.C., and an alternative proposal which only included 64B12-15.001, F.A.C.

Richard Williams commented that he would agree to the rule changes in 64B12-15.001, F.A.C.

John Girdler asked if there was a motion on the floor to accept rule 64B12-15.001, F.A.C.

Irene Stavros made a motion to accept rule 64B12-15.001, F.A.C.

Paul Wilford asked which proposal was the motion for.

Janet Hartman clarified overview of both proposals and read the changes in each section of the full Chapter 64B12-15, F.A.C**.** proposal.

John Girdler opened the floor to public comments. **(TS – 19:35 Minutes)**

Ramon Castro presented his comments.
Laurie Pierce presented her comments.
Wilbur Brewton presented his comments.

Janet Hartman confirmed that the rule changes in the alternate proposal of rule 64B12-15.001, F.A.C. will remain in Florida Administrative Code, but will be deemed ineffective as of January 1, 2021 at 12:00 A.M.

After discussion, the Board took the following action:

Motion: by Irene Stavros to accept the alternative proposed of rule 64B12-15.001, F.A.C.
Second: by Richard Williams
Vote: Passed Unanimously

Timothy Frizzell asked the SERC Questions.

Will the proposed rule amendments have adverse impact on small business?

Motion: by Paul Wilford voted “NO”
Second: by Richard Williams
Vote: Passed Unanimously

Will the proposed rule amendments be likely to directly or indirectly increase regulatory costs to any entity including government in excess of $200,000 in the aggregate in Florida within one year after implementation?

Motion: by Paul Wilford voted “NO”
Second: by Irene Stavros
Vote: Passed Unanimously

Should a violation of this rule or any part of this rule be designated as a minor violation?

Motion: by Paul Wilford voted “NO”
Second: by Richard Williams
Vote: Passed Unanimously

John Girdler referenced letters from the Board of Chiropractic Medicine.

Public Comments

Ramon Castro presented his comments.
Corey Sigouin presented his comments.

Motion: by Richard Williams to adjourn the meeting
Second: by Irene Stavros
Vote: Passed Unanimously

Meeting Adjourned at 6:11 P.M. EST

MEMORANDUM

TO: Janet Hartman, Executive Director, Board of Opticianry
FROM: Zachary Bell, Assistant General Counsel ZB
RE: **Voluntary Relinquishment**
SUBJECT: DOH v. James A. Matthews, III, A.O.
DOH Case Number 2019-04481
DATE: September 28, 2020

Enclosed you will find materials in the above-referenced case to be placed on the agenda for final agency action for the **October 23, 2020**, meeting of the board. The following information is provided in this regard.

Subject:	James A. Matthews, III, A.O.
Subject's Address of Record:	1349 Hideaway Dr. S. Saint Johns, Fl. 32259
Enforcement Address:	1349 Hideaway Dr. S Saint Johns, Fl. 32259
Subject's License No:	8662 Rank: DA
Licensure File No:	5750
Initial Licensure Date:	1/22/2019
Licensure Status:	39 - Voluntary Relinquish Pend. Board Action
Board Certification:	No
Required to Appear:	No
Current IPN/PRN Contract:	No
Allegation(s):	Section 484.014(1)(t), Florida Statutes (2018), by violating section 484.011, Florida Statutes (2018)
Prior Discipline:	No

Probable Cause Panel:	February 28, 2020 Starvos and Calvo
Subject's Attorney:	Pro Se
Complainant/Address:	Brenda Thompson 205 Elmwood Dr. Jacksonville, FL 32259
Materials Submitted:	Memorandum to the Board Voluntary Relinquishment Administrative Complaint Election of Rights Supplemental Investigative Report dated 7/25/2019 Final Investigative Report dated 3/8/2019 with Exhibits 1 through 6

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK: Amanda Morales
DATE: JUN 01 2020

PRACTITIONER REGULATION
LEGAL

2020 JUN -1 AM 11:32

STATE OF FLORIDA
BOARD OF OPTICIANRY

DEPARTMENT OF HEALTH,
Petitioner,

Case No. 2019-04481

JAMES ALLEN MATTHEWS, III, A.O.,

Respondent.
_____/

VOLUNTARY RELINQUISHMENT OF LICENSE

Respondent, James Allen Matthews, III, A.O., Apprentice Optician License Number AO 8662, hereby voluntarily relinquishes Respondent's license to practice opticianry in the State of Florida and states as follows:

1. Respondent's purpose in executing this Voluntary Relinquishment is to avoid further administrative action with respect to this cause. Respondent understands that acceptance by the Board of Opticianry ("Board") of this Voluntary Relinquishment shall be construed as disciplinary action against Respondent's license.

2. Respondent agrees to never reapply for licensure or certification pursuant to Chapter 484 Florida Statutes, in the State of Florida.

3. Respondent agrees to voluntarily cease practicing opticianry immediately upon executing this Voluntary Relinquishment. Respondent further agrees to refrain from practicing opticianry until this Voluntary Relinquishment is presented to the Board and the Board issues a written final order in this matter.

4. Upon the Board's acceptance of this Voluntary Relinquishment, Respondent agrees to waive all rights to seek judicial review of, or to otherwise challenge or contest the validity of, this Voluntary Relinquishment and of the Final Order of the Board incorporating this Voluntary Relinquishment.

5. Petitioner and Respondent hereby agree that upon the Board's acceptance of this Voluntary Relinquishment, each party shall bear its own attorney's fees and costs related to the prosecution or defense of this matter.

6. Respondent authorizes the Board to review and examine all investigative file materials concerning Respondent regarding the Board's consideration of this Voluntary Relinquishment. Respondent agrees that consideration of this Voluntary Relinquishment and other related materials by the Board shall not prejudice or preclude the Board, or any of its members, from further participation, consideration, or resolution of these proceedings if the terms of this Voluntary Relinquishment are not accepted by the Board.

DATED this 21 day of May, 2020.

James Allen Matthew, III, A.O.

STATE OF FLORIDA
COUNTY OF St Johns

Before me, personally appeared James Allen Matthew III whose identity is known to me by FLDL (type of identification) and who, under oath, acknowledges that his signature appears above. Sworn to and subscribed before me this 21st day of May, 2020.

Heather Taylor
Commission # GG118582
Expires: June 25, 2021
Bonded thru Aaron Notary

NOTARY PUBLIC

May 15, 2020

James Allen Matthew, III, A.O.
1349 Hideaway Drive S.
Saint Johns, Florida 32259

Re: Department of Health v. James Allen Matthew, III, A.O.
Case No. 2019-04481

Dear Mr. Matthew:

I am in receipt of your letter dated May 7, 2020, enclosing the Election of Rights wherein you state that you wish to voluntarily relinquish your license. I have enclosed a Voluntary Relinquishment form that will resolve the current disciplinary proceeding. Please sign the Voluntary Relinquishment in the presence of a notary (video notarization is now available in many places). Please return the notarized Voluntary Relinquishment to me by **May 31, 2020**. If I have not received the notarized Voluntary Relinquishment by May 31, 2020, the Department will proceed with an informal hearing as elected by you in the Election of Rights form.

If you have any questions, my phone number is (850) 558-5896.

Sincerely,

Dannie L. Hart
Assistant General Counsel

PRACTITIONER REGULATION
LEGAL
2020 JUN -1 AM 11:32

mrs Matthews
19 Nidaway Dr. S.
Johns FL 32259

PLEASE FOLD ENVELOPE TO THE RIGHT OF THE RETURN ADDRESS, FOLD AT DOTTED LINE

CERTIFIED MAIL

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32259
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Florida Department of Health
attn Dannie Hart
4052 Bald Cypress Way Bin C-65
Tallahassee FL 32399-3265

32399&3265 C001

ELECTION OF RIGHTS

I received the Administrative Complaint on the following date: 05/09/20

Persons seeking a hearing on an Administrative Complaint must file a petition for hearing with the agency within 21 days of receipt of written notice of the Administrative Complaint pursuant to Rule 28-106.111(2), Florida Administrative Code.

Any person who receives written notice of an Administrative Complaint and who fails to file a written request for a hearing within 21 days waives the right to request a hearing on such matters pursuant to Rule 28-106.111(4), Florida Administrative Code.

PLEASE SELECT ONLY 1 OF THE 2 OPTIONS.

OPTION 1. ✓ **I do not dispute the allegations** of material fact in the Administrative Complaint. I request a hearing be conducted pursuant to Section 120.57(2), Florida Statutes, where I will be permitted to appear, if I so choose, and submit oral and/or written evidence in mitigation of the complaint to the Board.

OPTION 2. _____ **I do dispute the allegations** of material fact contained in the Administrative Complaint and request this to be considered a petition for formal hearing, pursuant to Sections 120.569(2)(a) and 120.57(1), Florida Statutes, before an Administrative Law Judge appointed by the Division of Administrative Hearings. **Pursuant to the requirement of Uniform Rule 28-106.2015(5), Florida Administrative Code, I specifically dispute the following material facts (identified by paragraph number and fact disputed) in the Administrative Complaint:**

See attaches statement

PRACTITIONER REGULATION
LEGAL
2020 MAY 11 AM 11:53

PLEASE NOTE: If the Department does not receive your completed election of rights within 21 days of your receipt of the Administrative Complaint, your request for hearing will be denied.

Respondent's Signature
Address: 1349 Hideaway Dr S.
St Johns FL 32259

Lic. No.: _____

Phone No.: 706-691-691 Fax No.: _____

Email: BU9boy289@Gmail.com

Attorney/Qualified Representative*
Address: _____

Phone No.: _____

Fax No.: _____

Email: _____

***Qualified Representatives must file written requests to appear as such pursuant to Rule 28-106.106, Uniform Rules of Procedure.**

PLEASE MAIL AND/OR FAX COMPLETED FORM TO: Dannie L. Hart, Office of the General Counsel – Prosecution Services Unit 4052 Bald Cypress Way, Bin C-65 • Tallahassee, FL 32399-3265, EXPRESS MAIL: 2585 Merchants Row, Suite 105, PHONE: 850-245-4640 • FAX: 850-245-4684

PRACTITIONER REGULATION
LEGAL
2020 MAY 11 AM 11:53

May 7, 2020

To whom it may concern:

I do not deny the claim filed against me. I am very sorry for my actions and regret what I did.

I was terminated from Walmart over this situation. At the time of my termination, I wrote a statement and was informed by Walmart that my license would be revoked.

Therefore, I voluntarily give up my license and will not pursue an occupation in this field. I really would just like to put this mistake behind me.

If there is anything more I need to do to resolve this please call me at 706-691-6911. I will be moving out of state and would like to be sure this is settled before I leave.

Sincerely,

James Matthews

James Matthew
1349 Hideaway Dr. S.
St Johns FL 32259

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Florida Dept of Health
Attn: Dannie L Hart
4052 Bald Cypress Way Bin C 65
Tallahassee, FL 32399-3265

USPS TRACKING® NUMBER

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK: Amanda Morales
DATE: 9/28/2020

STATE OF FLORIDA
BOARD OF OPTICIANRY

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO. 2019-04481**

JAMES ALLEN MATTHEWS, III, A.O.

RESPONDENT.
_____/

NOTICE OF SCRIVENER'S ERROR

Petitioner, Department of Health, by and through its undersigned counsel, files this Notice of Scrivener's Error, and as grounds therefore states:

1. On or about March 2, 2020, an Administrative Complaint was filed in the above-referenced matter, a copy of the Administrative Complaint is attached as Exhibit A.

2. Due to an error, Respondent's abbreviated profession title was listed as "D.A." on both the case style and in the opening paragraph of the Administrative Complaint.

3. Respondent's abbreviated professional title should have been listed as "A.O." in both the case style and the opening paragraph.

4. Due to an error, numbered paragraph 3 of the Administrative Complaint states that Respondent's address of record is "1749 Hideaway Drive South, Saint Johns, Florida 32259."

5. Paragraph 3 should have stated Respondent's address of record as "1349 Hideaway Drive South, Saint Johns, Florida 32259."

6. The correction of the aforementioned errors is of no prejudice to Respondent and makes no substantive changes to the Administrative Complaint.

7. This Notice shall take effect upon its filing with the Clerk of the Department.

DATED this 28th day of September, 2020.

Respectfully submitted,

Zachary Bell

Zachary Bell
Assistant General Counsel
Florida Bar No. 105735
Department of Health
Prosecution Services Unit
4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399-3265
Phone: 850-245-4666
Fax: 850-245-4684
Email: zachary.bell@flhealth.gov

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing has been provided by U.S. Mail to Respondent, James Allen Matthews, III, A.O., at 1349 Hideaway Drive South, Saint Johns, Florida 32259, this 28th day of September, 2020.

Zachary Bell

Zachary Bell
Assistant General Counsel

STATE OF FLORIDA
BOARD OF OPTICIANRY

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO. 2019-04481**

JAMES ALLEN MATTHEWS III, D.A.,

RESPONDENT.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW, Petitioner, Department of Health, by and through its undersigned counsel, and files this Administrative Complaint before the Board of Opticianry against Respondent, James Allen Matthews III, D.A., and in support thereof alleges:

1. Petitioner is the state agency charged with regulating the practice of Opticianry pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 484, Florida Statutes.

2. At all times material to this Administrative Complaint, Respondent was an apprentice optician within the state of Florida, having been issued license number DA8662.

3. Respondent's address of record is 1749 Hideaway Drive South, Saint Johns, Florida 32259.

4. On or around February 1, 2019, Respondent dispensed eye glasses to Patients T.M. and D.E. while no licensed optician was onsite.

5. Section 484.014(1)(t), Florida Statutes (2018), provides that violating any provision of chapter 484, chapter 456, or the rules adopted by the board, constitutes grounds for disciplinary action.

6. Section 484.011, Florida Statutes (2018), provides that no person other than a licensed optician may engage in the practice of opticianry, except that a licensed optician may delegate to non-licensed supportive personnel those duties, tasks, and functions which fall within the purview of Section 484.002(3), Florida Statutes. All such delegated acts shall be performed under the direct supervision of a licensed optician, who shall be responsible for all such acts performed by persons under her or his supervision.

7. Section 484.002, Florida Statues (2018) defines direct supervision as supervision where the licensee remains on the premises while all work is being done and gives final approval to any work performed by an employee.

8. Based on the foregoing, Respondent violated Section 484.014(1)(t), Florida Statutes (2018), by violating Section 484.011, Florida Statutes (2018) by practicing opticianry without a licensed optician providing direct supervision.

WHEREFORE, the Petitioner respectfully requests that the Board of Opticianry enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

SIGNED this 28th **day of** February, **2020.**

Scott Rivkees, M.D.
State Surgeon General

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK: Aimee Moreno
DATE: MAR 02 2020

Amanda M. Godbey
Assistant General Counsel
Fla. Bar No. 1000352
Florida Department of Health
Prosecution Services Unit
4052 Bald Cypress Way, Bin #C65
Tallahassee, FL 32399-3265
Telephone: (850) 558-9873
Facsimile: (850) 245-4684
Email: Amanda.Godbey@flhealth.gov

PCP: 2-28-2020
PCP Members: Starvos and Calvo

NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or her behalf if a hearing is requested.

A request or petition for an administrative hearing must be in writing and must be received by the Department within 21 days from the day Respondent received the Administrative Complaint, pursuant to Rule 28-106.111(2), Florida Administrative Code. If Respondent fails to request a hearing within 21 days of receipt of this Administrative Complaint, Respondent waives the right to request a hearing on the facts alleged in this Administrative Complaint pursuant to Rule 28-106.111(4), Florida Administrative Code. Any request for an administrative proceeding to challenge or contest the material facts or charges contained in the Administrative Complaint must conform to Rule 28-106.2015(5), Florida Administrative Code.

Mediation under Section 120.573, Florida Statutes, is not available to resolve this Administrative Complaint.

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.

Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Florida HEALTH

Ron DeSantis
Governor

Vision: To be the **Healthiest State** in the Nation

February 14, 2019

CONFIDENTIAL TO:
James Allen Matthews III
1749 Hideaway Dr. S.
Saint Johns, FL 32259

Case Number: 2019-04481

Dear Mr. Matthews:

We are currently investigating the enclosed document received by the Department of Health. This investigation was initiated after it was determined that you may have violated the Practice Act of your profession.

Within 20 days of receiving this letter, you may:

- submit a **written response** to the address below; **or**
- call our office to schedule an **interview**.

Please provide a copy of your **curriculum vitae** and identify your **specialty** even if you choose not to submit a response. Include the above-referenced case number in any correspondence that you send.

Florida law requires that this case and all investigative information remain confidential until 10 days after the Probable Cause Panel has determined that a violation occurred, or you give up the right to confidentiality. Therefore, the contents of the investigation cannot be disclosed to you or the general public. You may make a written request for a copy of the investigative file and it will be sent to you when the investigation is complete.

You are not required to answer any questions or give any statement, and you have the right to be represented by an attorney. It is not possible to estimate how long it will take to complete this investigation because the circumstances of each investigation differ.

The mission of the Department of Health is to protect, promote & improve the health of all people in Florida through integrated state, county and community efforts. If you have any questions, please call us at 904-381-6044.

Sincerely,

Daniel R Bible
Medical Quality Assurance Investigator

/DRB

Enclosure(s): Case Summary, Complainant Correspondence.

Florida Department of Health
Division of Medical Quality Assurance
1912 Hamilton Street Suite 104 • Jacksonville, FL 32210
PHONE: 904-381-6022 • FAX: 904-381-6050
FloridaHealth.gov

PHAB Accredited Health Department
Public Health Accreditation Board

INV Form 354, Revised 10/10, 6/07, Created 10/07

February 14, 2019

CONFIDENTIAL
BRENDA KAY THOMPSON
205 ELMWOOD DR.
JACKSONVILLE, FL 32259

Reference Number: 201904481
Subject: JAMES ALLEN MATTHEWS III

Dear Sir or Madam:

Please be advised that the Investigative Services Unit is conducting an investigation on JAMES ALLEN MATTHEWS III and I am the investigator assigned to your case.

Florida law requires that all information in a complaint remain confidential until 10 days after probable cause is found. Patient names and records are never released to the public.

The mission of the Department of Health is to protect, promote & improve the health of all people in Florida through integrated state, county, & community efforts. If you have any questions, please call me at (904)381-6022.

Sincerely,

Daniel Bible

STATE OF FLORIDA BOARD OF OPTICIANRY

DEPARTMENT OF HEALTH
Complainant,

v. DOH CASE NO. 2019-04481

James A. Matthews, III, A.O.
Respondent,

NOTICE OF MEETING
FINAL AGENCY ACTION BY: VOLUNTARY RELINQUISHMENT

TO: James A. Matthews, III, A.O.
1349 Hideaway Dr. S.
Saint Johns, Florida 32259

PLEASE TAKE NOTICE that DOH case # 2019-04481 is on the October 23, 2020 agenda for review by the Board of Opticianry. The meeting is scheduled to begin at 9:00 A.M., EST via teleconference call. The dial-in information is:

Dial-in #: 1 (888) 585-9008 Participation Code: 123-475-828 #

You are not required to appear at this meeting but failure to appear will waive your right to be heard in this matter. It is requested that you contact me in via my email address listed below with your intentions to attend the meeting. This is a public meeting and participants in this public meeting should be aware that these proceedings are being recorded and that an audio file of the meeting will be posted to the board's website.

Certificate of Service

I, HEREBY CERTIFY that a true and correct copy of the above and foregoing Notice of Meeting has been sent by U.S. Mail to the above address on this September 25, 2020.

Eric Pottschmidt
Program Operations Administrator
Email: Eric.Pottschmidt@flhealth.gov
Phone: (850) 245-4292, Facsimile: (850) 413-6982
4052 Bald Cypress Way, Bin # C08
Tallahassee, Florida 32399-3258

STATE OF FLORIDA BOARD OF OPTICIANRY

DEPARTMENT OF HEALTH
Complainant,

v. DOH CASE NO. 2019-04481

James A. Matthews, III, A.O.
Respondent,

NOTICE OF MEETING
FINAL AGENCY ACTION BY: VOLUNTARY RELINQUISHMENT

TO: Brenda Thompson
205 Elmwood Dr.
Jacksonville, Florida 32259

PLEASE TAKE NOTICE that DOH case # 2019-04481 is on the October 23, 2020 agenda for review by the Board of Opticianry. The meeting is scheduled to begin at 9:00 A.M., EST via teleconference call. The dial-in information is:

Dial-in #: 1 (888) 585-9008 Participation Code: 123-475-828 #

You are not required to appear at this meeting but failure to appear will waive your right to be heard in this matter. It is requested that you contact me in via my email address listed below with your intentions to attend the meeting. This is a public meeting and participants in this public meeting should be aware that these proceedings are being recorded and that an audio file of the meeting will be posted to the board's website.

Certificate of Service

I, HEREBY CERTIFY that a true and correct copy of the above and foregoing Notice of Meeting has been sent by U.S. Mail to the above address on this September 25, 2020.

Eric Pottschmidt
Program Operations Administrator
Email: Eric.Pottschmidt@flhealth.gov
Phone: (850) 245-4292, Facsimile: (850) 413-6982
4052 Bald Cypress Way, Bin # C08
Tallahassee, Florida 32399-3258

DOH/PROSECUTOR'S REPORT

BOARD OF OPTICIANRY

Meeting Date: October 23, 2020

TO: Janet Hartman, Executive Director

FROM: Rose Garrison, Assistant General Counsel

DATE: October 13, 2020

RE: Current Open/Pending Opticianry Cases

There are currently **10 open disciplinary cases** in the PSU Detailed Inventory.

· Under Legal Review:	3
Cases with probable cause recommendation:	3
· Probable cause found:	4
· Cases pending before DOAH:	1
· Cases agendaed for Board:	1
· Cases Older Than One Year:	6

Currently there are a total of 10 active cases in the Department's Opticianry inventory. Of those cases, six are year and older cases and all but one has had a finding of probable cause.

We currently have one case that has gone through a Formal Hearing and is pending a Recommended Order from an Administrative Law Judge. As always, the Department's prosecutors are working diligently to timely resolve all outstanding cases, and we are very close to doing so.

I would request that the Board entertain a motion to allow the Department to continue prosecuting its year and older cases. Thank you.

10/13/2020

Florida Board of Opticianry:

I am requesting a review for early termination of my probation. All the requirements set by the board have been met at this time. I truly appreciate your consideration in this matter.

Kind Regards,

Minina Mckie, DO- 4049

Lloyd Holness
Associate Professor, Broward College
P: +1 (954) 2012017 / 954- 253 1043
E: lholness@broward.edu | **W:** broward.edu
A: 1000 Coconut Creek Blvd.
Coconut Creek, FL 33066

10/09/2020

Attention: Ms. Sondra Nelson Allen.
Department of Health/ Division of Medical Quality
Assurance/Compliance Management Unit
4052 Bald Cypress Way, Bin C-76
Tallahassee, FL 32399-3275

Re Minina Mckie- DO 4049 CASE- 2018-13101.

Good Day Ms. Nelson Allen.

This serve as written notice to the Board of Opticianry that Ms. Minina Mckie- DO 4049 is fully compliant with all requirements of the board pursuant to CASE- 2018-1310. I have been her Monitor since March 18th, 2020 and can attest to her compliance in all areas recommended by the Board.

MS. Mckie is aware of the requirements to complete 6 hours of Laws and Rules continuing education by December 11, 2020. She has completed 4 of the six hours and will complete the remaining 2 before the December deadline.

I enthusiastically recommend her to the board for consideration of early termination of probation.

Sincerely,
Lloyd Holness

Lloyd Holness
Associate Professor,
Broward College

Final Order No. DOH-19-1881-FOT-MQA

FILED DATE - DEC 12 2019
Department of Health
By: Anne Marks
Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF OPTICIANRY

DEPARTMENT OF HEALTH,

Petitioner,

vs.

Case No.: 2018-13101
License No.: DO 4049

MININA MCKIE,

Respondent.
_____/

FINAL ORDER

THIS MATTER came before the Board of Clinical Laboratory Personnel (Board) at a duly noticed public meeting on November 15, 2019, in Fort Lauderdale, Florida. Pursuant to the Administrative Complaint, attached hereto as Exhibit A, it was alleged that Respondent violated specified sections of Chapter 484, Florida Statutes.

Petitioner was represented by Rose Garrison, Assistant General Counsel, with the Department of Health. Respondent was present and was represented by Cynthia Barnett Hibnick, Esquire.

Service of the Administrative Complaint was made upon Respondent pursuant to Section 120.60(5), Florida Statutes. Respondent filed an Election of Rights to the Administrative Complaint requesting a hearing pursuant to Section 120.57(2), Florida Statutes. Petitioner has filed a Motion for Final Order After Hearing Not Involving Disputed Issues of Material Facts and a Motion to Assess Costs in Accordance with Section 456.072(4).

The prosecuting attorney offered the investigative file into evidence to prove the facts as alleged in the Administrative Complaint and for the purposes of determining penalty. The investigative file was received into evidence and the Board finds that the uncontested facts

adequately support the allegations. After a complete review of the record in this matter, including consideration of the Administrative Complaint, any written evidence or testimony, and any mitigating or aggravating circumstances, the Board makes the following findings and conclusions:

FINDINGS OF FACT

1. The allegations of fact set forth in the Administrative Complaint are approved, adopted, and incorporated herein by reference as the findings of fact by the Board.

2. There is competent, substantial evidence to support the Board's findings and conclusions.

3. There is competent, substantial evidence to support the discipline imposed pursuant to the disciplinary guidelines found at rule 64B29-2.001(3).

4. The parties have reached an agreement as to the discipline terms. The parties' agreement was approved by the board. The terms of the parties' agreement are included herein.

CONCLUSIONS OF LAW

4. The Petitioner's Motion for Hearing Not Involving Disputed Issues of Material Fact is granted.

5. The conclusions of law alleged and set forth in the Administrative Complaint are approved and adopted and incorporated herein by reference as the conclusions of law of the Board.

6. The violations set forth in the Administrative Complaint warrant disciplinary action by the Board.

7. Based upon the Findings of Fact, the Board concludes that the licensee violated Section 484.014(1)(b), Florida Statutes, by procuring or attempting to procure a license by

misrepresentation, bribery, or fraud or through an error of the department of the board.

8. The Board is empowered by Section 484.014(2) and/or 456.072(2), Florida Statutes, to impose a penalty against Respondent.

THEREFORE, IT IS **ORDERED AND ADJUDGED**, that:

9. **Probation**. The Respondent is hereby placed on probation with a board approved monitor for a term of 1 year for the purpose of observing Continuing Education compliance of her program and students. The Respondent may seek early termination from the board after written notice of compliance by the board approved monitor.

10. **Fine and Costs**. Pursuant to mitigating factors found by the Board, and the agreement of the parties, the Board imposes a fine of **$1,500.00** and costs of **$3,500.00** for a total of **$5,000.00**, to be paid in full within **5 years** of the filing date of this Final Order. Same shall be paid at the rate of no less than $1,000.00 per year from the date of the filing of this Final Order.

11. **Continuing Education**. The Respondent shall complete 6 hours of Continuing Education regarding Laws and Rules within **one year** of the filing date of this Final Order.

12. The Department withdrew its Motion for Costs.

This Final Order shall become effective upon filing with the Clerk of the Department of Health.

DONE AND ORDERED this 11th day of December, 2019.

BOARD OF OPTICIANRY

Janet Hartman, Executive Director
on behalf of John B. Girdler, Chair

NOTICE OF RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW PURSUANT TO SECTION 120.68, FLORIDA STATUTES. REVIEW PROCEEDINGS ARE GOVERNED BY THE FLORIDA RULES OF APPELLATE PROCEDURE. SUCH PROCEEDINGS ARE COMMENCED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE AGENCY CLERK OF THE DEPARTMENT OF HEALTH AND A SECOND COPY, ACCOMPANIED BY FILING FEES PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL, FIRST DISTRICT, OR WITH THE DISTRICT COURT OF APPEAL IN THE FLORIDA APPELLATE DISTRICT WHERE THE PARTY RESIDES. THE NOTICE OF APPEAL MUST BE FILED WITHIN THIRTY (30) DAYS OF THE FILING DATE OF THE ORDER TO BE REVIEWED.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by U.S. Mail to: **Minina McKie c/o Cynthia Barnett Hibnick, Esquire**, 1 Alhambra Plz, Suite 1410, Coral Gables, FL 33134-5247; and by electronic mail to: **Rose Garrison** Assistant General Counsel, Department of Health, rose.garrison@flhealth.gov; and **Timothy Frizzell**, Assistant Attorney General, timothy.frizzell@myfloridalegal.com, on December 12, 2019.

Anna Mans

Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF OPTICIANRY

DEPARTMENT OF HEALTH,

PETITIONER,

v. **CASE NO. 2018-13101**

MININA MCKIE, D.O.,

RESPONDENT.
_____/

FIRST AMENDED ADMINISTRATIVE COMPLAINT

COMES NOW Petitioner, Department of Health, by and through its undersigned counsel, files this First Amended Administrative Complaint before the Board of Opticianry ("the Board") against Respondent, Minina Mckie, D.O., and in support thereof alleges:

1. Petitioner is the state agency charged with regulating the practice of opticianry pursuant to Section 20.43, Florida Statutes; Chapter 456, Florida Statutes; and Chapter 484, Florida Statutes.

2. At all times material to this Complaint, Respondent was a licensed optician within the State of Florida, having been issued license number DO 4049.

3. Respondent's address of record is 4526 Southwest 179th Way, Miramar, Florida 33029.

4. At all times relevant to this Complaint, the Respondent was employed at Broward College as the program director for opticianry.

5. Rule 64B12-9.0015(4)(c), Florida Administrative Code, requires that applicants for an opticianry license successfully complete a two-hour live technical practice continuing education course on fitting and adjusting provided by a Board approved provider ("fitting and adjusting course").

6. In April of 2017, the Respondent arranged for one or more graduating Broward College opticianry students to obtain certification that they had completed the fitting and adjusting course when the Respondent knew or had reason to know that the student(s) had not, in fact, taken this course.

7. Section 484.014(1)(b), Florida Statutes (2016), provides that procuring or attempting to procure a license for any other person by making or causing to be made any false representation, constitutes grounds for discipline against a licensee.

8. The Respondent procured or attempted to procure a license for another person by making or causing to be made a false representation when she arranged for a fitting and adjusting course certification to be issued to one

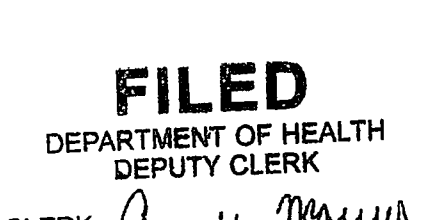
or more graduating Broward College students when the Respondent knew or had reason to know that those students had not taken the course, thus enabling those students to apply for licensure.

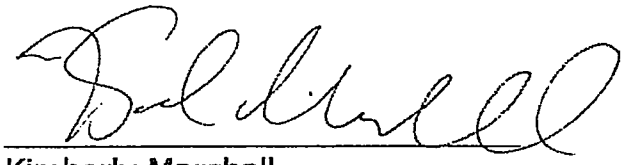
9. Based upon the foregoing, the Respondent has violated Section 484.014(1)(b), Florida Statutes (2016).

WHEREFORE, Petitioner respectfully requests that the Board of Opticianry enter an order imposing one or more of the following penalties: permanent revocation or suspension of Respondent's license, restriction of practice, imposition of an administrative fine, issuance of a reprimand, placement of the Respondent on probation, corrective action, refund of fees billed or collected, remedial education and/or any other relief that the Board deems appropriate.

Signatures appear on next page

SIGNED this 9th **day of** May**, 2019.**





Kimberly Marshall
Assistant General Counsel
DOH Prosecution Services Unit
4052 Bald Cypress Way, Bin C-65
Tallahassee, Florida 32399-3265
Florida Bar # 123880
Phone 850-558-9810
FAX 850-245-4684
kimberly.marshall@flhealth.gov

PCP Date: February 25, 2019
Panel Members: Slattery, Calvo, and Stavros

NOTICE OF RIGHTS

Respondent has the right to request a hearing to be conducted in accordance with Section 120.569 and 120.57, Florida Statutes, to be represented by counsel or other qualified representative, to present evidence and argument, to call and cross-examine witnesses and to have subpoena and subpoena duces tecum issued on his or her behalf if a hearing is requested. A request or petition for an administrative hearing must be in writing and must be received by the Department within 21 days from the day Respondent received the Administrative Complaint, pursuant to Rule 28-106.111(2), Florida Administrative Code. Please send your request to:

If Respondent fails to request a hearing within 21 days of receipt of this Administrative Complaint, Respondent waives the right to request a hearing on the facts alleged in this Administrative Complaint pursuant to Rule 28-106.111(4), Florida Administrative Code. Any request for an administrative proceeding to challenge or contest the material facts or charges contained in the Administrative Complaint must conform to Rule 28-106.2015(5), Florida Administrative Code.

Please be advised that mediation under Section 120.573, Florida Statutes, is not available for administrative disputes involving this agency action.

NOTICE REGARDING ASSESSMENT OF COSTS

Respondent is placed on notice that Petitioner has incurred costs related to the investigation and prosecution of this matter. Pursuant to Section 456.072(4), Florida Statutes, the Board shall assess costs related to the investigation and prosecution of a disciplinary matter, which may include attorney hours and costs, on the Respondent in addition to any other discipline imposed.

STATE OF FLORIDA
BOARD OF OPTICIANRY

NOTICE OF MEETING

TO: Minina McKie, D.O.
4526 SW 179th Way
Miramar, Florida, 33029

PLEASE TAKE NOTICE that your request for early termination of probation is on the October 23, 2020 agenda for review by the Board of Opticianry. The meeting is scheduled to begin at 9:00 A.M., EST via teleconference call. The dial-in information is:

Dial-in #: 1 (888) 585-9008 Participation Code: 123-475-828 #

You are not required to appear at this meeting. However, you are encouraged to attend. It may be helpful for you to appear in the event the Board has any questions concerning this review.

This is a public meeting and participants in this public meeting should be aware that these proceedings are being recorded and that an audio file of the meeting will be posted to the board's website.

Certificate of Service

I, HEREBY CERTIFY that a true and correct copy of the above and foregoing Notice of Meeting has been sent by U.S. Mail to the above address on this October 13, 2020.

Eric Pottschmidt
Program Operations Administrator
Email: Eric.Pottschmidt@flhealth.gov
Phone: (850) 245-4292, Facsimile: (850) 413-6982
4052 Bald Cypress Way, Bin # C08
Tallahassee, Florida 32399-3258

FLORIDA | Board *of* Opticianry

APPLICATION SUMMARY

ADAMS, WENDI LYNNE

Apprentice Optician

2002 / 5990

Application Completion Date: 01/13/2020

Other Related License(s): None

ONGOING REVIEW

Original application review was placed on the agenda at the April 24, 2020 general business meeting.

Applicant was present. Discussion involved how much work she was performing in the field of opticianry and doing the work of an optician. Discussion also involved her sponsor being an optometrist, thus producing concerns that she may be working more as a Certified Optometric Assistant (COA), rather than an optician.

After discussion, the Board suggested Wendi Adams research what opticianry is and then research the NOA Career Progression Program. Once complete, the Board would like Wendi Adams to return to the Board with a better idea of what an optician does, and a plan of obtaining an optician education in order to move forward to become a licensed optician. An Order was voted on and approved requiring Wendi Adams to appear at one of the next two scheduled meetings. The Board reviewed her criminal history and noted her criminal history will not be at issue any further in this matter.

Application was placed on the June 30, 2020 general business meeting. The applicant failed to appear due to personal conflict. By an Order requiring appearance, this was the first of the two opportunities to appear for review.

Application has been placed on the general business meeting for October 23, 2020. By an Order requiring appearance this is the second of the two opportunities to appear for review.

CRIMINAL HISTORY

Arrest / Offense Date: **1994-1995**

Worthless Checks – Three Case Numbers

Level: Misdemeanor

Plea: Nolo Contendere

Disposition: Adjudicated Guilty

Costs / Fine / Restitution: $355.82

Summary Prepped By: Eric Pottschmidt

FLORIDA | Board *of* Opticianry

APPLICATION SUMMARY

CRIMINAL HISTORY

Arrest / Offense Date: **1998**

Forgery

Level: Felony

Plea: Guilty

Disposition: Jail 8 months

NOT DISCLOSED ON HER APPLICATION

CRIMINAL HISTORY

Arrest / Offense Date: **2005**

Possession of Controlled Substance – More than 20 grams of Cannabis.

Level: 3rd Degree Felony

Plea: Nolo Contendere

Disposition: Adjudication Withheld

Probation: 12 months

Costs / Fine / Restitution: $1,416.00

CRIMINAL HISTORY

Arrest / Offense Date: **2006**

Opposing an Officer without Violence

Level: Misdemeanor

Plea: Nolo Contendere

Disposition: Adjudication Withheld – Community Service

Costs / Fine / Restitution: $243.00

NOT DISCLOSED ON HER APPLICATION

STAFF NOTES – TIMELINE

Summary Prepped By: Eric Pottschmidt

FLORIDA | Board *of* Opticianry

APPLICATION SUMMARY

- **1994-1995** – Misdemeanor Arrest – Three case numbers for worthless checks in Florida. Applicant did disclose on her optician application.
- **1998** – Felony Arrest – Forgery - Arrested in Florida, extradited and charged in Texas. **Applicant did not disclose on her optician application.** This is noted by the applicant on her self-explanation to Board of Nursing.
- **2005** – 3rd Degree Felony Arrest - Possession of controlled substance, more than 20 grams of cannabis. Applicant did disclose on her optician application.
    - **Applicant answered NO on her optician application to question #2 under: Medicaid/Medicare.**
- **2006** – Misdemeanor Arrest - Opposing an officer without violence. **Applicant did not disclose on her optician application.**
- **2009** – Applicant applied for Certified Nursing Assistant license but denied by the Board of Nursing in May 2010 by issuing Notice of Intent to Deny based on noncompliance with 456.0635(2)(a), F.S. Her nursing profession code is 4401; File # 506010.
    - **Applicant answered NO on her optician application to the question under: Discipline History – Refused Licensure.**
- **2010** – Applicant applied for licensure as chiropractic assistant; application expired 2012.
- **2020** – Applicant applied for Apprentice Optician.

Summary Prepped By: Eric Pottschmidt

FILED
DEPARTMENT OF HEALTH
DEPUTY CLERK
CLERK: Bridget Coates
DATE: MAY 04 2020

STATE OF FLORIDA
BOARD OF OPTICIANRY

In Re: APPLICATION FOR APPRENTICE OPTICIAN

WENDI LYNNE ADAMS
2002/5990

ORDER

THIS MATTER came before the Board of Opticianry (Board) at a duly noticed public meeting on April 24, 2020, via telephone conference call. The Board was represented by Timothy Frizzell, Assistant Attorney General. The Applicant was present but was not represented by counsel.

1. The application file reveals that the Applicant answered yes to the criminal history question on her application. Additionally, the Board had questions regarding the Applicant's employment and her expected duties as an apprentice optician, that she was unable to answer.

2. Section 456.013(3)(c), Florida Statutes (2019), provides:

> In considering applications for licensure, the board, or the department when there is no board, may require a personal appearance of the applicant. If the applicant is required to appear, the time period in which a licensure application must be granted or denied shall be tolled until such time as the applicant appears. However, <u>if the applicant fails to appear before the board at either of the next two regularly scheduled board meetings, or fails to appear before the department within 30 days if there is no board, the application for licensure shall be denied (emphasis added).</u>

3. The Board voted to allow the Applicant to obtain additional information regarding her proposed duties and to require the Applicant to appear before the Board to answer questions regarding her application. The Board noted that her criminal history will not be at issue any further in this matter.

Therefore, it is **ORDERED AND ADJUDGED** that:

The Applicant is required to appear before the Board at one of the Board's next two (2) regularly scheduled meetings. The Applicant must advise the Board office which meeting she will attend. Notification must be provided to the Board office at least **seven (7) days** prior to the date of the meeting.

This order shall become effective upon filing with the Clerk of the Department of Health.

DONE AND ORDERED this 29 day of April, 2020.

BOARD OF OPTICIANRY

Janet Hartman, Executive Director
on behalf of John B Girdler, III, Chair

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing was furnished by U.S. Mail to: **Wendi Lynne Adams**, 1010 Barcia Drive, Pensacola, FL 32503; and by electronic mail to **Timothy Frizzell**, Assistant Attorney General, timothy.frizzell@myfloridalegal.com on 4 May, 2020.

Brooklyn Conte
DEPUTY AGENCY CLERK

Application

Application Detail

License Type:	**Apprentice Optician**
Profession Number:	**2002 - Apprentice Optician**
File Number:	**5990**
Application:	**Apprentice Optician License Application**
Application Date:	**01/02/2020**

Suitability Question(s)

Are you 18 years of age or older?	**Yes**
NOTE: Exam eligilibity requires graduation from an accredited high school or its equivalent. Do you have an eligible sponsor?	**Yes**

Application Questions

Military Veteran Fee Waiver - I have been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**
Military Veteran Spouse Fee Waiver - I am the spouse of a military veteran who has been honorably discharged from a branch of the United States Armed Forces within the previous 60 months.	**No**

Personal Detail

First Name:	**WENDI**
Middle/Second Name:	**LYNNE**
Last Name/Surname:	**ADAMS**
Birthdate:	[redacted]
Gender:	**Female**

Race:	**White**
Social Security Number:	[redacted]

Addresses

Main Address

Address:	**1010 Barcia Dr** **ESCAMBIA** **pensacola, FL** **32503** **US**
Phone Number:	**850-361-6845**
E-mail Address:	**wadams@healthcarewithinreach.org**
Home	**jaejelsmama@yahoo.com**

Physical Location

Address:	**1010 Barcia Dr** **ESCAMBIA** **pensacola, FL** **32503** **US**
Phone Number:	**850-361-6845**

Education History

Name of High School	**Milton High School**
High School Address	**5445 Stewart St** **Milton Fl** **32570**
Date Completed	**05/30/1992**
Name and Address of Optical School (if any)	**none**

Health History

In the last 5 years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past 5 years?	**N/A**
In the last 5 years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?	**N/A**

During the last 5 years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice your profession within the past 5 years?	**N/A**
During the last 5 years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice your profession?	**N/A**
In the last 5 years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last 5 years?	**N/A**
During the last 5 years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that impaired your ability to practice your profession within the last 5 years?	**N/A**
A. Do you have any condition that currently impairs your ability to practice your profession with reasonable skill and safety?	**No**
B. Are you using medications, other drugs, narcotics, or intoxicating chemicals that impair your ability to practice your profession with reasonable skill and safety?	**No**

Criminal Offense 1

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense?	**Yes**

You must include all misdemeanors and felonies, even if the court withheld adjudication so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. Provide the data below and a statement regarding the incident. Make sure to include an explanation of the charges, dates, jurisdictions and dispositions. You will need to add a separate record for each incident

Offense:	**bad check**
Date of Offense:	**01/01/1996**
State or Jurisdiction:	**florida**
Under Appeal:	**No**
Applicant Statement:	**paid fine**

Criminal Offense 2

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense?	**Yes**

You must include all misdemeanors and felonies, even if the court withheld adjudication so that you would not have a record of conviction. Driving under the influence or driving while impaired is not a minor traffic offense for purposes of this question. Provide the data below and a statement regarding the incident. Make sure to include an explanation of the charges, dates, jurisdictions and dispositions. You will need to add a separate record for each incident

Offense:	**posession**
Date of Offense:	**08/20/2006**
State or Jurisdiction:	**florida**
Under Appeal:	**No**
Applicant Statement:	**Put on probation for a year. SUCCESSFULLY COMPLETED**

Discipline History - Denied

Have you ever been denied the right to take an Opticianry licensure examination?	**No**

Discipline History - Refused Licensure

Have you ever been denied licensure, certification, or registration for Opticianry or any health-related profession or the renewal thereof in any state?	**No**

Discipline History - Discipline

Have you ever had a license to practice a profession revoked, suspended, or otherwise acted against in a disciplinary proceeding in any state?	**No**

Discipline History - Pending

Is there currently pending, in any jurisdiction, a complaint against your professional conduct or competency in a psychotherapy or counseling-related profession?	**No**

Discipline History - Five Questions

1. Acts of dishonesty, fraud, or deceit	**No**
2. Lying on a resume or misrepresentation	**No**
3. Academic misconduct, including acts such as cheating or plagiarism	**No**
4. Theft	**No**
5. Sexual harassment	**No**

Medicaid / Medicare

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?	**No**
2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?	**No**
3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, F.S.?	**No**
4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?	**No**
5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?	**No**

Related Licenses Deleted

Related Licenses Added

Relation Name:	**Primary Sponsor:**
Required:	**Y**
Your Role:	**PRI-SPONSOsubordinate**
Other Party Role:	**Primary Sponsor:**
	CHARBONNEAU, MARY U
	1801 - Optometrist - 3406
	CLEAR - 2021-02-28

Attachments

Document Type: Criminal History Documents File Name: 202001021018.pdf

Fees

Apprentice Appl Fee	**$60.00**
Total Amount Due:	**$60.00**

Attestation

I hereby authorize all hospitals, institutions, or organizations, personal physicians, employers (past or present), business and professional associates (past or present), and all government agencies and instrumentalities (local, state, federal, or foreign) to release to the Department of Health any information, files, or records requested by the Department in connection with the processing of this application. I further authorize the Department to release to the organizations, individuals, and groups listed above any information which is material to my application.

I understand that it is my duty and responsibility as an applicant for licensure to supplement my application after it has been submitted if and when any material change in circumstances or conditions occur which might affect the Board's decision concerning my eligibility for examination or licensure. Such supplement is required by s.456.072, F.S., and 456.013(1)(a), F.S. Failure to do so may result in disciplinary action by the Board including denial of licensure.

I have carefully read the questions in the foregoing application and have answered them completely without reservations of any kind. I declare that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to s. 456.067, F.S., or criminal penalties pursuant to s. 775.082, s. 775.083, or s. 775.084, F.S. Should I furnish any false information on this application, I hereby acknowledge that such act may constitute cause for denial, suspension, or revocation of any license to practice in the State of Florida.

I hereby state that my sponsor and I have reviewed, together, Chapter 484, Part I, Florida Statutes (F.S.), and Chapter 64B12, Florida Administrative Code (F.A.C.), and specifically Rule Chapter 64B12-16, F.A.C. I fully understand my responsibilities to my sponsor, the Board of Opticianry and the Department of Health, and the limitations of being registered in the apprenticeship program herein designated. I understand that it is my responsibility to keep informed of any changes to Chapter 484, Part I, F.S., and 64B12, F.A.C.

I understand that pursuant to s. 456.013(1)(a), F.S., an incomplete application shall expire 1 year after initial filing.

I understand that pursuant to Rule 64B12-16.003(4)(a), F.A.C., I am required to complete a two-hour Apprentice/Sponsor Orientation Course within one year of registration in the apprenticeship program. I have also informed my sponsor(s) that if they attend a two-hour Apprenticeship/Sponsor Orientation Course, the course will count toward either the elective or the laws and rules continuing education requirement for renewal of their optician license.

Attestation Answer: Yes

BOARD OF OPTICIANRY
SPONSOR REGISTRATION FORM

Print clearly in black ballpoint pen or type all information.

APPRENTICE INFORMATION

Apprentice Full Name: WENDI LYNNE ADAMS

Number of hours this apprentice will work per week under direct supervision of a sponsor: 40

PRIMARY SPONSOR GENERAL INFORMATION (Signature required below)

Sponsor Name MARY CHARBONNEAU Business Name COMMUNITY HEALTH NORTH WEST FLORIDA

Address/City/State/Zip 2315 W. JACKSON ST

Telephone Number: (850) 436 4630 FAX (850) 436 2095

Primary Sponsor's License Number OPC 3406 Profession OPTOMETRIST

Rule 64B12-16.003, F.A.C., requires the apprentice to complete training in filling, fitting and adapting contact lenses as a part of the apprenticeship training. Will this training be provided by the primary sponsor?

☒ **Yes** ☐ **No [One of these boxes must be checked.]**

SECONDARY SPONSOR GENERAL INFORMATION (if applicable)

Secondary Sponsor Name _____ Business Name _____

Address/City/State/Zip _____

Telephone Number ( ) _____ FAX ( ) _____

Secondary Sponsor's License Number _____ Profession _____

Rule 64B12-16.003, F.A.C., requires the apprentice to complete training in filling, fitting and adapting contact lenses as a part of the apprenticeship training. Will this training be provided by the secondary sponsor?

☐ **Yes** ☐ **No [If this section is completed, one of these boxes must be checked.]**

I state that I do dispense eyewear and maintain all of the equipment required by Rule 64B12-10.007, F.A.C., on the same premises where the apprentice works. I further state that my apprentice and I have reviewed, **together**, Chapter 484, Part I, Florida Statutes, and Rule Chapter 64B12-16, Florida Administrative Code. I declare that I fully understand my responsibilities to my apprentice and to the Board of Opticianry and the Department of Health, as a properly registered sponsor of an apprentice registered in the Opticianry apprenticeship program.

Signature of Primary Sponsor — Date 1/6/20 — Signature of Secondary Sponsor (if applicable)

National Healthcareer Association

nha

Wendi Adams

has successfully completed the requirements set forth by the NHA as a Certified Clinical Medical Assistant

Douglas Viehland, CAE
Executive Director-Certifications

Certification #B7S8Q9K5

Eff. Date 10/19/2015
Exp. Date 10/19/2021

Please Note: All certifications are required to maintain **CE Credits.**
This certificate should only be used in conjunction with a validated NHA ID Card when used as proof of Certification.

community health
northwest florida
HealthcareWithinReach.org

October 8, 2019

To Whom It May Concern,

I have had the pleasure of working with Wendi Adams for several years at Community Health Northwest Florida (formerly Escambia Community Clinics). She gets along well with others interacts well with both patients and staff in her clinical role here as a medical assistant. She is reliable, dependable and kind.

If you have any questions, feel free to reach me at (850) 413-1149.

Thanks,

Juanita Fleming, M.D.

Main Office
2315 West Jackson Street
Pensacola, FL 32505
T 850.436.4630 **F** 850.436.2095

community health
northwest florida
HealthcareWithinReach.org

October 8, 2019

Escambia County School District
75 N. Pace Blvd.
Pensacola, FL 32505

RE: Reference for Wendi Adams

I am writing in support of Wendi Adams being cleared to perform optometry services for the children of C.A. Weis Elementary as part of the partnership between Community Health Northwest Florida and C.A. Weis as a Community School.

Ms. Adams has been employed with Community Health since 2015, and has not only been an excellent member of our team, but has also show our patients the care and respect that is the foundation of our mission of serving the most vulnerable in our community. Her work ethic, attention to detail, and compassion is evident every day she walks through our doors.

I strongly request she be granted permission to continue her great work with the students of C.A. Weiss. Her enthusiasm and commitment to serving our shared population will be of benefit to all.

Please feel free to reach out with any questions or concerns you might have.

Thank you for your consideration in this matter.

Sincerely,

Chandra Smiley

Chandra Smiley, Chief Executive Officer
Community Health Northwest Florida

community health
northwest florida
HealthcareWithinReach.org

October 07,2019

To Whom it May Concern ,

I met Ms. Wendi Adams in 2014 . Ms. Adams is one of the best things about CHNWF . She is not just a coworker or an employee but a friend to everyone in the company . She shows impeccable attendance not just on scheduled work days but also volunteering and participating in many of the company's outreach activities . She has participated every year in the Cooperate Cup Games . I have got to be apart of our Company's Work Fair which I had the pleasure of working along side of Wendi during that day . I have had the opportunity of witnessing her love and compassion for each patient that she works with time and time again . Wendi is a great dependable coworker but she is also an amazing mom and person .

Sincerely ,

Jennifer Johnson

Clinic Officer Manager .

J. Johnson

Dr. Mary Charbonneau, Optometrist
2315 West Jackson Street
Pensacola, FL 32505
T 850.436.4630 ext. 90515 F 850.436.2095
mcharbonneau@HealthcareWithinReach.org

community health
northwest florida
OPTOMETRIC VISION CARE

October 7, 2019

To the Escambia County School Board,

I am writing this letter on behalf of Wendi Adams, my optometric technician and medical assistant here at Community Health Northwest Florida. I have been working with her since March 2016 and trust her implicitly. She is caring, dedicated and honest. I consider her a friend as well as a valued coworker, and have gotten to know her 2 children and her mother. I have even had them all over to my house several times as guests.

As for her character, I would highly recommend her for any role in the clinical setting, including working with children.

Please let me know if you have any questions.

Sincerely,

Dr. Mary Charbonneau, Optometrist
Cell (850)426-1747

STATE OF FLORIDA BOARD OF OPTICIANRY

NOTICE OF MEETING

TO: Wendi Lynne Adams
1010 Barcia Dr.
Pensacola, FL 32503

PLEASE TAKE NOTICE that your application is on the October 23, 2020 agenda for review by the Board of Opticianry @ 9:00 a.m. EST via teleconference call. The dial-in information is:

Dial-in #: 1 (888) 585-9008 Participation Code: 123-475-828#

As noted in the Order requiring appearance, the applicant is required to appear at one of the Board's next two (2) regularly scheduled meetings. This meeting is the second meeting.

This is a public meeting and participants in this public meeting should be aware that these proceedings are being recorded and that an audio file of the meeting will be posted to the board's website.

CERTIFICATE OF SERVICE

I, HEREBY CERTIFY that a true and correct copy of the above and foregoing Notice of Meeting has been sent by U.S. Mail to the above address on this September 22, 2020.

Eric Pottschmidt
Program Operations Administrator
Email: Eric.Pottschmidt@flhealth.gov
Phone: (850) 245-4292, Facsimile: (850) 413-6982
4052 Bald Cypress Way, Bin # C08
Tallahassee, Florida 32399-3258

STATE OF FLORIDA
BOARD OF OPTICIANRY

NOTICE OF MEETING

TO: **Wade Delk**
National Commission of State Opticianry Regulatory Boards
2025 Woodlane Drive
Woodbury, MN 55125-2998

PLEASE TAKE NOTICE that questions pertaining to the National Commission of State Opticianry Regulatory Board's Basic Examination have been placed on the October 23, 2020 agenda for review by the Board. The meeting is scheduled to begin @ 9:00 a.m. EST via teleconference call. The dial-in information is:

Dial-in #: 1 (888) 585-9008 Participation Code: 123-475-828#

The Board of Opticianry is requesting you, or a representative from the National Commission of State Opticianry Regulatory Board's Examinations (NCSORB), to appear in order to review and answer questions from the Board of Opticianry.

This is a public meeting and participants in this public meeting should be aware that these proceedings are being recorded and that an audio file of the meeting will be posted to the board's website.

CERTIFICATE OF SERVICE

I, HEREBY CERTIFY that a true and correct copy of the above and foregoing Notice of Meeting has been sent by U.S. Mail to the above address on this October 6, 2020.

Eric Pottschmidt
Program Operations Administrator
Email: Eric.Pottschmidt@flhealth.gov
Phone: (850) 245-4292, Facsimile: (850) 413-6982
4052 Bald Cypress Way, Bin # C08
Tallahassee, Florida 32399-3258

STATE OF FLORIDA
BOARD OF OPTICIANRY

NOTICE OF MEETING

TO: **Wade Delk**
National Commission of State Opticianry Regulatory Boards
2025 Woodlane Drive
St. Paul, MN 55125-2998

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Eric Pottschmidt
Program Operations Administrator
Email: Eric.Pottschmidt@flhealth.gov
Phone: (850) 245-4292, Facsimile: (850) 413-6982
4052 Bald Cypress Way, Bin # C08
Tallahassee, Florida 32399-3258

COMPLIANCE REPORT - AS OF OCTOBER 13, 2020

Total Licensees in Report	3,989	Of the 2,193 Who are Incomplete…		
Total Licensees Complete	1,796	Need 10 Hours or less to complete.		42.00%
Total Licensees Incomplete	2,193	Need 11 - 19 Hours to complete.		19.50%
% Complete	45.02%	Need All 20 Hours to Complete		38.50%
% Incomplete	54.98%			

Status	License number	Profession	Compliance status	Hours Required	Hours Completed	Hours Not Completed
Active/Clear	DO2181	Optician	Completed	20	20	0
Active/Clear	DO5869	Optician	Completed	20	20	0
Active/Clear	DO3372	Optician	Completed	20	20	0
Active/Clear	DO2023	Optician	Completed	20	20	0
Active/Clear	DO3157	Optician	Completed	20	20	0
Active/Clear	DO3193	Optician	Completed	20	20	0
Active/Clear	DO1288	Optician	Completed	20	20	0
Active/Clear	DO1576	Optician	Completed	20	20	0
Active/Clear	DO1835	Optician	Completed	20	20	0
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Active/Clear	DO5300	Optician	Completed	20	20	0
Active/Clear	DO4824	Optician	Completed	20	20	0
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Active/Clear	DO891	Optician	Completed	20	20	0
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Active/Clear	DO6789	Optician	Completed	20	20	0
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Active/Clear	DO6957	Optician	Completed	20	20	0
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Active/Clear	DO7476	Optician	Completed	0	0	0
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Active/Clear	DO7156	Optician	Completed	10	10	0
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Active/Clear	DO6862	Optician	Not completed	20	0	20
Active/Clear	DO7062	Optician	Not completed	20	0	20
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Active/Clear	DO3547	Optician	Not completed	20	0	20
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Active/Clear	DO7066	Optician	Not completed	20	0	20
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Active/Clear	DO2868	Optician	Not completed	20	0	20
Active/Clear	DO6801	Optician	Not completed	20	0	20
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Active/Clear	DO5816	Optician	Not completed	20	0	20
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Active/Clear	DO3990	Optician	Not completed	20	0	20
Active/Clear	DO6410	Optician	Not completed	20	0	20
Active/Clear	DO3736	Optician	Not completed	20	0	20
Active/Clear	DO4931	Optician	Not completed	20	0	20

Table 15
Revenue/Expenditures/Cash Balances
July 1, 2019 - June 30, 2020

MQA TF PROFESSIONS	BEGINNING CASH BALANCE	REVENUES	EXPENDITURES	ENDING CASH BALANCE	UNLICENSED ACT CASH BAL
Acupuncture	$ 858,950	$ 768,860	$ 453,460	$ 1,174,350	$ (847)
Anesthesiologist Assistants	$ 255,582	$ 17,201	$ 69,728	$ 203,055	$ 2,960
Athletic Trainers	$ 531,326	$ 82,729	$ 220,018	$ 394,037	$ 38,079
Chiropractic	$ 1,884,737	$ 2,106,255	$ 1,523,216	$ 2,467,776	$ 76,241
Clinical Laboratory	$ 440,084	$ 736,516	$ 730,956	$ 445,644	$ 264,823
Certified Nursing Assistants	$ (157,301)	$ 4,210,582	$ 4,965,584	$ (912,303)	$ 1,985,470
CSW,MFT,MHC	$ 1,546,548	$ 984,315	$ 2,466,044	$ 64,819	$ 254,823
Dentistry	$ (4,449,098)	$ 5,081,740	$ 3,179,882	$ (2,547,240)	$ (1,134,745)
Dental Hygienist	$ 1,008,879	$ 1,262,336	$ 736,649	$ 1,534,566	$ 256,081
Dental Labs	$ 311,121	$ 161,943	$ 115,848	$ 357,216	$ (243,551)
Dietetics & Nutrition	$ 748,192	$ 119,051	$ 373,356	$ 493,887	$ (275,569)
Electrolysis	$ (1,033,082)	$ 263,050	$ 362,477	$ (1,132,509)	$ (358,879)
EMS (EMT & PMT)	$ (4,266,474)	$ 272,222	$ 1,273,991	$ (5,268,243)	$ (18,414)
Hearing Aid Specialist	$ 599,373	$ 59,893	$ 260,428	$ 398,838	$ (98,282)
Massage Therapy	$ (12,309,226)	$ 4,811,973	$ 5,335,317	$ (12,832,570)	$ (3,757,762)
Medical Physicists	$ 247,203	$ 45,626	$ 80,801	$ 212,028	$ 13,232
Medicine	$ 13,641,686	$ 19,398,807	$ 17,572,271	$ 15,468,222	$ (2,362,620)
Midwifery	$ (821,707)	$ 119,424	$ 119,578	$ (821,861)	$ (104,411)
Nursing	$ 13,050,343	$ 16,880,185	$ 19,196,999	$ 10,733,529	$ 9,241,248
Nursing Home Administrator	$ 820,245	$ 196,672	$ 401,043	$ 615,874	$ 28,213
Occupational Therapy	$ 599,337	$ 382,169	$ 664,777	$ 316,729	$ 299,424
Opticianry	$ (16,036)	$ 93,373	$ 518,680	$ (441,343)	$ (894,495)
Optometry	$ 1,748,837	$ 116,469	$ 518,224	$ 1,347,082	$ 34,773
Orthotist & Prosthetist	$ 434,854	$ 353,614	$ 194,704	$ 593,764	$ (144,780)
Osteopathic Medicine	$ 2,588,270	$ 4,211,523	$ 2,501,697	$ 4,298,096	$ 115,783
Pharmacy	$ 29,315	$ 7,773,631	$ 7,503,566	$ 299,380	$ 691,368
Physical Therapy	$ 237,026	$ 2,562,924	$ 1,427,201	$ 1,372,749	$ 498,027
Physician Assistant	$ 2,711,737	$ 4,161,550	$ 1,864,197	$ 5,009,090	$ 162,819
Podiatry	$ 306,373	$ 783,812	$ 440,710	$ 649,475	$ 30,774
Psychology	$ 2,105,790	$ 1,282,394	$ 849,848	$ 2,538,336	$ (139,492)
Radiological Technicans	$ (406,764)	$ 1,084,694	$ 932,385	$ (254,455)	$ (671)
Respiratory Therapy	$ 672,958	$ 206,977	$ 673,495	$ 206,440	$ 318,237
School Psychology	$ 96,871	$ 192,405	$ 165,235	$ 124,041	$ 14,221
Speech-Language & Audiology	$ 1,229,664	$ 1,454,213	$ 996,267	$ 1,687,610	$ 290,870
Telehealth Providers	$ -	$ 1	$ 164,848	$ (164,847)	$ -
Total	$ 25,245,613	$ 82,239,129	$ 78,853,480	$ 28,631,262	$ 5,082,948

NOTE: NICA is a pass through and is excluded.
PRN Student Pilot Project not included

Table 16
Projected Cash Balances
Medical Quality Assurance Trust Fund

MQA TF PROFESSIONS	Projected Ending Cash Balance 2020-2021	Projected Ending Cash Balance 2021-2022	Projected Ending Cash Balance 2022-2023	Projected Ending Cash Balance 2023-2024	Projected Ending Cash Balance 2024-2025	Projected Ending Cash Balance 2025-2026
Acupuncture	$ 959,458	$ 1,387,767	$ 1,261,570	$ 1,701,493	$ 1,576,519	$ 2,011,390
Anestiologist Asst	$ 259,530	$ 253,538	$ 325,119	$ 319,931	$ 391,776	$ 386,238
Athletic Trainers	$ 573,408	$ 535,224	$ 742,817	$ 708,824	$ 917,177	$ 881,361
Chiropractic	$ 1,408,110	$ 2,621,566	$ 1,726,206	$ 2,988,597	$ 2,100,826	$ 3,341,931
Clinical Laboratory	$ 655,680	$ 543,040	$ 760,460	$ 677,252	$ 901,110	$ 805,099
Cert Nurs Asst	$ (1,251,726)	$ (2,306,840)	$ (2,781,785)	$ (3,641,635)	$ (4,085,766)	$ (5,030,555)
Cert Social Worker	$ -	$ -	$ -	$ -	$ -	$ -
CSW,MFT,MHC	$ 1,356,550	$ (191,636)	$ 1,022,588	$ (437,808)	$ 795,219	$ (703,365)
Dentistry	$ (5,329,646)	$ (4,057,978)	$ (6,933,503)	$ (5,525,870)	$ (8,380,223)	$ (7,031,733)
Dental Hygienist	$ 1,113,912	$ 1,728,326	$ 1,418,995	$ 2,056,136	$ 1,749,443	$ 2,376,698
Dental Labs	$ 307,020	$ 402,048	$ 379,414	$ 476,840	$ 454,446	$ 550,829
Dietetics & Nutrition	$ 735,825	$ 554,921	$ 830,231	$ 659,663	$ 936,380	$ 761,316
Electrolysis	$ (1,374,424)	$ (1,458,353)	$ (1,709,736)	$ (1,780,153)	$ (2,029,383)	$ (2,105,678)
EMS (EMT & PMD)	$ (4,524,465)	$ (5,718,682)	$ (5,024,819)	$ (6,168,525)	$ (5,463,313)	$ (6,628,991)
Hearing Aid Spec	$ 607,783	$ 502,758	$ 737,740	$ 638,428	$ 874,754	$ 772,957
Massage Therapy	$ (16,882,516)	$ (18,488,266)	$ (22,706,128)	$ (24,083,650)	$ (28,263,332)	$ (29,740,131)
Medical Physicists	$ 288,904	$ 298,142	$ 390,700	$ 401,199	$ 494,054	$ 504,004
Medicine	$ 17,016,741	$ 19,174,200	$ 21,481,633	$ 24,264,900	$ 26,681,513	$ 29,192,560
Midwifery	$ (856,718)	$ (837,549)	$ (873,966)	$ (851,372)	$ (887,434)	$ (866,330)
Naturopathy	$ -	$ -	$ -	$ -	$ -	$ -
Nursing	$ 11,581,902	$ 12,922,744	$ 14,110,552	$ 16,118,654	$ 17,424,783	$ 19,142,632
Nursing Home Admin	$ 1,006,723	$ 947,069	$ 1,379,898	$ 1,329,072	$ 1,763,574	$ 1,708,908
Occupational Therapy	$ 715,866	$ 457,231	$ 860,738	$ 624,072	$ 1,032,354	$ 786,131
Opticianry	$ (411,179)	$ (845,684)	$ (830,172)	$ (1,246,378)	$ (1,227,535)	$ (1,651,701)
Optometry	$ 1,895,507	$ 1,724,642	$ 2,367,278	$ 2,206,041	$ 2,851,792	$ 2,686,367
Ortho & Prosth	$ 537,637	$ 739,728	$ 728,795	$ 935,693	$ 925,299	$ 1,130,106
Osteopathic	$ 3,197,681	$ 5,056,606	$ 4,261,003	$ 6,196,689	$ 5,410,066	$ 7,312,362
Pharmacy	$ (790,209)	$ (880,807)	$ (2,165,710)	$ (1,959,819)	$ (3,194,860)	$ (3,117,939)
Physical Therapy	$ 410,683	$ 1,419,623	$ 529,302	$ 1,596,104	$ 714,474	$ 1,756,107
Physician Assistant	$ 3,876,157	$ 6,831,590	$ 6,070,666	$ 9,077,847	$ 8,323,574	$ 11,308,245
Podiatry	$ 333,048	$ 596,691	$ 322,613	$ 601,998	$ 330,121	$ 602,659
Psychology	$ 1,959,407	$ 2,777,147	$ 2,385,646	$ 3,221,797	$ 2,833,913	$ 3,662,055
Radiological Tech	$ (173,859)	$ (214,238)	$ (176,114)	$ (182,143)	$ (138,455)	$ (159,425)
Respiratory Therapy	$ 237,013	$ (258,475)	$ 548,694	$ 77,558	$ 889,696	$ 407,967
School Psychology	$ 39,899	$ 121,518	$ 44,532	$ 130,036	$ 53,683	$ 137,496
Speech-Language	$ 1,339,080	$ 1,893,057	$ 1,661,658	$ 2,246,223	$ 2,018,930	$ 2,590,189
Telehealth Providers	$ (329,847)	$ (494,839)	$ (659,839)	$ (824,831)	$ (989,831)	$ (1,154,822)
Total	$ 20,488,935	$ 27,735,826	$ 22,487,079	$ 32,552,863	$ 27,785,343	$ 36,624,936

NICA and Unlicensed Activity are excluded from the amounts shown above.

A Review of the Adequacy of Renewal Fees

MQA Trust Fund (Chapter 456)							
	Profession	FY 20-21 & 21-22 Estimated Expend	Number of Licensees (1)	Cost to Regulate (1)	Renewal Fee Cap	Current Renewal Fee (3)	Sufficient (4) Current Renewal Fee
1.	Acupuncture	$ 530,123	2,551	$208	$ 500	$275/$150	Yes
2.	Anesthesiologist Asst	$ 65,251	494	$132	$ 1,000	$ 200	Yes
3.	Athletic Trainers	$ 242,197	2,897	$84	$200/$100	$100/$50	Yes
4.	Chiropractic	$ 2,622,704		$275			Yes
A.	Chiropractic		6,464		$ 500	$ 250	
B.	Chiropractic PA		233		$ 250	$55/$28	
C.	Chiropractic Asst		2,851		$ 25	$ 25	
5.	Clinical Laboratory	$ 1,876,369		$109			Yes
A.	Director		231		$ 150	$ 130	
B.	Supervisor		5,251		$ 150	$ 110	
C.	Technologist		9,771		$ 150	$ 90	
D.	Technician		1,560		$ 150	$ 50	
E.	Training Program		47		$ 300	$ 300	
F.	Inactive		386		$ 50	$ 50	
6.	Certified Nursing Asst	$ 10,549,905	160,932	$66	$ 50	$ 50	
7.	CSW,MFT,MHC	$ 5,533,070		$195			
A.	Clincial Social Work		12,366		$250/$50	$115/$50	
B.	Marriage and Fam Ther		2,416		$250/$50	$115/$50	
C.	Mental Health Couns		13,551		$250/$50	$115/$50	
D.	Interns		0		$ 100	$ 75	
E.	Mstr Cert Social Worker		7		$ 250	$150/$50	
8.	Dentistry	$ 7,300,792	14,641	$499	$ 300	$ 300	
9.	Dental Hygienist	$ 1,076,663	14,482	$74	$ 300	$ 80	Yes
10.	Dental Labs	$ 107,389	778	$138	$ 300	$ 175	Yes
11.	Dietetics & Nutrition	$ 522,786	5,300	$99	$ 500	$ 75	Yes
12.	Electrolysis	$ 733,270	2,182	$336	$ 100	$ 100	
13.	Hearing Aid Spec	$ 379,366	1,071	$354	$ 600	$375/$375	Yes
14.	Massage Therapy	$ 12,676,230		$277			
A.	Massage Therapist		37,566		$200/$250	$ 100	
B.	Massage Establishment		8,198		$ 150	$ 100	
15.	Medical Physicists	$ 83,644		$118			Yes
A.	Medical Physicists		653		$ 500	$ 150	
B.	Medical Phys In Trng		58		No Cap	$ 100	
16.	Medicine	$ 35,475,495	77,168	$460	$ 500	$360/$120	Yes
17.	Midwifery	$ 155,472	196	$793	$ 500	$500/$500	
18.	Nursing	$ 37,799,884		$89			Yes
A.	Registered Nurse (RN)		323,932		No Cap	$65/$55	
B.	Licensed Practical Nurse		64,259		No Cap	$65/$55	
C.	Advanced Practice Registered Nurse (APRN)		37,254		No Cap	$ 50	
19.	Nursing Home Admin	$ 521,561	1,757	$297	No Cap	$ 325	Yes
20.	Occupational Therapy	$ 1,395,739	16,599	$84	No Cap	$ 55	Yes
21.	Opticianry	$ 1,059,495	4,033	$263	$350/$50	$125/$50	
22.	Optometry	$ 774,821		$212			Yes
A.	Optometrist		3,629		$ 300	$ 300	
B.	Optometry Faculty		25		No Cap	$ 100	
23.	Orthotists & Prosthetics	$ 224,713	672	$334	$ 500	$ 400	Yes
24.	Osteopathic	$ 3,647,289	10,539	$346	$ 500	$400/$200	Yes
25.	Pharmacy	$ 16,509,595		$177			
A.	Pharmacists		33,414		$ 250	$ 200	
B.	Consultant Pharmacist		3,182		$ 250	$ 100	
C.	Nuclear Pharmacist		192		$ 250	$ 100	
D.	Pharmacies Permit		10,727		$ 250	$ 250	
E.	Pharmacy Technicians		46,016		$ 50	$ 50	
26.	Physical Therapy	$ 3,055,890		$105			Yes
A.	Physical Therapist		17,751		$ 200	$75/$50	
B.	Physical Therapist Asst		11,256		$ 150	$75/$50	
27.	Physician Assistant	$ 2,554,136	10,111	$253	$ 500	$275/$150	Yes
28.	Podiatry	$ 805,260		$351			Yes
A.	Podiatric Medicine		1,792		$ 350	$ 350	
B.	Cert Podiatric X-Ray Asst		500		No Cap	$ 75	
29.	Psychology	$ 1,108,315		$186			Yes
A.	Psychologist		5,952		$ 500	$ 295	
B.	Limited License		11		$ 500	$ 25	
30.	Respiratory Therapy	$ 1,495,254	13,299	$112	$200/$50	$120/$50	Yes
31.	School Psychology	$ 212,959	882	$241	$ 500	$190/$150	Yes
32.	Speech-Lang, P & A	$ 1,537,544		$112			Yes
A.	Pathologist & Audiologist		12,219		$500/$100	$ 75	
B.	P & A Assist		1,465		No Cap	$ 50	
	Total Fund (4)	$ 152,633,181	1,015,769	$150			

Notes:

1. Cost to regulate is computed by adding FY 20-21 and FY 21-22 projected expenditures and dividing by the total number of non-delinquent active and inactive licensees eligible to renew as of June 30, 2020.
2. Two amounts in the column for fee caps and/or current fees represent two different amounts for active and inactive licensees.
3. If there is a projected positive cash balance at June 30, 2026, then the current renewal fee is deemed to be sufficient.

HISTORICAL AND PROJECTED CASH BALANCES

	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Projected	Projected	Projected	Projected	Projected
	Cash Balance	Cash Balance	Cash Balance	Cash Balance	Cash Balance	Cash Balance	Cash Balance	Cash Balance	Cash Balance	Cash Balance	Cash Balance	Cash Balance	Cash Balance
MQA TRUST FUND	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**2020-21**	**2021-22**	**2022-23**	**2023-24**	**2024-25**
BOARD/COUNCIL													
Acupuncture	357,215	721,929	458,944	946,223	874,616	1,180,021	858,950	1,174,350	959,458	1,387,767	1,261,570	1,701,493	1,576,519
Anesthesiologist Asst	13,078	19,647	110,627	145,938	286,677	229,196	255,582	203,055	259,530	253,538	325,119	319,931	391,776
Athletic Trainers	149,529	73,754	255,966	261,634	487,461	397,289	531,326	394,037	573,408	535,224	742,817	708,824	917,177
Chiropractic Medicine	1,618,406	1,886,435	1,314,105	2,721,645	2,103,152	3,169,426	1,884,737	2,467,776	1,408,110	2,621,566	1,726,206	2,988,597	2,100,826
Clinical Lab Personnel	282,604	44,025	121,353	13,990	148,261	70,152	440,084	445,644	655,680	543,040	760,460	677,252	901,110
Cert. Nursing Assistant	(2,079,003)	(814,471)	(768,711)	23,680	(225,869)	(396,559)	(157,301)	(912,303)	(1,251,726)	(2,306,840)	(2,781,785)	(3,641,635)	(4,085,766)
Cert. Social Worker	(129,529)	(129,473)	(132,626)	0	0	0	0	0	0	0	0	0	0
CSW, MFT & MHC	2,479,855	920,593	2,172,521	507,457	1,811,259	371,705	1,546,548	64,819	1,356,550	(191,636)	1,022,588	(437,808)	795,219
Dentistry	(716,665)	254,414	(2,144,333)	(1,163,216)	(3,776,737)	(2,334,422)	(4,449,098)	(2,547,240)	(5,329,646)	(4,057,978)	(6,933,503)	(5,525,870)	(8,380,223)
Dental Hygienist	521,464	1,063,509	601,514	1,244,591	998,998	1,478,533	1,008,879	1,534,566	1,113,912	1,728,326	1,418,995	2,056,136	1,749,443
Dental Labs	268,771	316,483	246,872	364,350	355,646	397,525	311,121	357,216	307,020	402,048	379,414	476,840	454,446
Dietetics and Nutrition	259,256	124,716	441,971	417,059	776,486	496,755	748,192	493,887	735,825	554,921	830,231	659,663	936,380
Electrolysis	(555,377)	(527,535)	(638,545)	(585,551)	(706,406)	(741,635)	(1,033,082)	(1,132,509)	(1,374,424)	(1,458,353)	(1,709,736)	(1,780,153)	(2,029,383)
EMS (EMT & PMT)	(3,435,852)	(4,442,867)	(3,845,162)	(4,767,548)	(3,976,433)	(4,820,380)	(4,266,474)	(5,268,243)	(4,524,465)	(5,718,682)	(5,024,819)	(6,168,525)	(5,463,313)
Hearing Aid Specialists	188,369	(81,637)	264,778	187,404	558,765	429,216	599,373	398,838	607,783	502,758	737,740	638,428	874,754
Massage Therapy	(968,026)	(595,212)	(3,511,398)	(5,259,602)	(8,812,903)	(9,618,370)	(12,309,226)	(12,832,570)	(16,882,516)	(18,488,266)	(22,706,128)	(24,083,650)	(28,263,332)
Medical Physicists	99,317	95,828	131,562	140,983	216,026	185,498	247,203	212,028	288,904	298,142	390,700	401,199	494,054
Medicine	11,000,662	9,111,009	6,636,402	5,189,878	8,916,058	11,505,899	13,641,686	15,468,222	17,016,741	19,174,200	21,481,633	24,264,900	26,681,513
Midwifery	(834,964)	(860,708)	(900,115)	(852,199)	(862,573)	(790,064)	(821,707)	(821,861)	(856,718)	(837,549)	(873,966)	(851,372)	(887,434)
Naturopathic	(304,378)	(305,321)	(306,584)	0	0	0	0	0	0	0	0	0	0
Nursing	6,657,842	5,264,746	7,511,111	7,094,178	11,938,958	11,923,553	13,050,343	10,733,529	11,581,902	12,922,744	14,110,552	16,118,654	17,424,783
Nursing Home Admin.	123,358	(59,636)	286,153	269,212	641,845	491,448	820,245	615,874	1,006,723	947,069	1,379,898	1,329,072	1,763,574
Occupational Therapy	583,500	223,670	500,451	138,764	508,489	207,451	599,337	316,729	715,866	457,231	860,738	624,072	1,032,354
Opticianry	674,264	380,172	450,711	125,008	242,332	(90,449)	(16,036)	(441,343)	(411,179)	(845,684)	(830,172)	(1,246,378)	(1,227,535)
Optometry	988,472	522,207	1,102,454	957,901	1,706,530	1,211,358	1,748,837	1,347,082	1,895,507	1,724,642	2,367,278	2,206,041	2,851,792
Orthotists & Prosthetists	38,223	223,071	51,462	341,047	324,782	494,883	434,854	593,764	537,637	739,728	728,795	935,693	925,299
Osteopathic Medicine	930,503	1,924,956	727,326	2,474,708	1,993,662	3,812,660	2,588,270	4,298,096	3,197,681	5,056,606	4,261,003	6,196,689	5,410,066
Pharmacy	(322,427)	145,497	22,237	91,415	494,795	820,010	29,315	299,380	(790,209)	(880,807)	(2,165,710)	(1,959,819)	(3,194,860)
Physical Therapy	314,230	901,373	106,832	795,325	181,246	1,152,494	237,026	1,372,749	410,683	1,419,623	529,302	1,596,104	714,474
Physician Assistant	417,310	1,402,833	562,278	2,456,158	1,797,927	3,873,964	2,711,737	5,009,090	3,876,157	6,831,590	6,070,666	9,077,847	8,323,574
Podiatric Medicine	44,122	431,365	164,222	490,163	182,734	524,627	306,373	649,475	333,048	596,691	322,613	601,998	330,121
Psychology	673,321	1,665,879	1,044,529	2,152,299	1,851,456	2,822,168	2,105,790	2,538,336	1,959,407	2,777,147	2,385,646	3,221,797	2,833,913
Radiological Technican	(2,033,081)	(2,162,881)	(2,284,873)	(456,544)	(789,285)	(237,894)	(406,764)	(254,455)	(173,859)	(214,238)	(176,114)	(182,143)	(138,455)
Respiratory Therapy	937,369	359,427	1,055,358	475,171	1,303,664	636,327	672,958	206,440	237,013	(258,475)	548,694	77,558	889,696
School Psychology	69,510	116,196	46,885	148,513	135,845	248,660	96,871	124,041	39,899	121,518	44,532	130,036	53,683
Speech-Language, P & A	935,853	1,261,312	843,156	1,478,170	1,447,850	1,797,132	1,229,664	1,687,610	1,339,080	1,893,057	1,661,658	2,246,223	2,018,930
Telehealth Providers	0	0	0	0	0	0	0	(164,847)	(329,847)	(494,839)	(659,839)	(824,831)	(989,831)
TOTAL	19,247,101	19,475,305	12,699,433	18,568,204	23,135,314	30,898,177	25,245,613	28,631,262	20,488,935	27,735,826	22,487,079	32,552,863	27,785,343
	10	10	9	6	7	8	8	8	9	11	9	10	9

CYCLICAL DEFICIT

CHRONIC DEFICIT (Two or more consecutive years)

NICA is a pass through and is excluded from the projections. Unlicensed Activity is excluded.

PROFESSION-BY-PROFESSION REVENUE AND EXPENDITURE PROJECTIONS
(NOT INCLUDING UNLICENSED ACTIVITY)

	ENDING CASH BAL 6/30/2020	LICENSED ALLOCATION OF CASH WITHDRAWAL	ESTIMATED REVENUES FY 20-21	ESTIMATED EXPEND FY 20-21	ENDING CASH BAL 06/30/21	ESTIMATED REVENUES FY 21-22	ESTIMATED EXPEND FY 21-22	ENDING CASH BAL 06/30/22	ESTIMATED REVENUES FY 22-23	ESTIMATED EXPEND FY 22-23	ENDING CASH BAL 06/30/23	ESTIMATED REVENUES FY 23-24	ESTIMATED EXPEND FY 23-24	ENDING CASH BAL 06/30/24	ESTIMATED REVENUES FY 24-25	ESTIMATED EXPEND FY 24-25	ENDING CASH BAL 06/30/25	ESTIMATED REVENUES FY 25-26	ESTIMATED EXPEND FY 25-26	ENDING CASH BAL 06/30/26
MQA TRUST FUND																				
Acupuncture	$ 1,174,350	$ 94,073	$ 74,281	$ 195,101	$ 959,458	$ 763,331	$ 335,023	$ 1,387,767	$ 74,281	$ 200,478	$ 1,261,570	$ 763,331	$ 323,409	$ 1,701,493	$ 74,281	$ 199,255	$ 1,576,519	$ 763,331	$ 328,461	$ 2,011,390
Anesthesiologist Asst	$ 203,055	$ 16,266	$ 114,800	$ 42,059	$ 259,530	$ 17,200	$ 23,193	$ 253,538	$ 114,800	$ 43,218	$ 325,119	$ 17,200	$ 22,389	$ 319,931	$ 114,800	$ 42,954	$ 391,776	$ 17,200	$ 22,738	$ 386,238
Athletic Trainers	$ 394,037	$ 31,565	$ 332,219	$ 121,283	$ 573,408	$ 82,729	$ 120,914	$ 535,224	$ 332,219	$ 124,626	$ 742,817	$ 82,729	$ 116,722	$ 708,824	$ 332,219	$ 123,866	$ 917,177	$ 82,729	$ 118,546	$ 881,361
Chiropractic	$ 2,467,776	$ 197,685	$ 349,089	$ 1,211,071	$ 1,408,110	$ 2,625,090	$ 1,411,633	$ 2,621,566	$ 349,089	$ 1,244,449	$ 1,726,206	$ 2,625,090	$ 1,362,699	$ 2,988,597	$ 349,089	$ 1,236,860	$ 2,100,826	$ 2,625,090	$ 1,383,985	$ 3,341,931
Clinical Lab	$ 445,644	$ 35,699	$ 1,273,092	$ 1,027,357	$ 655,680	$ 736,372	$ 849,012	$ 543,040	$ 1,273,092	$ 1,055,672	$ 760,460	$ 736,372	$ 819,580	$ 677,252	$ 1,273,092	$ 1,049,234	$ 901,110	$ 736,372	$ 832,383	$ 805,099
Cert Nurs Asst	$ (912,303)	$ -	$ 4,577,684	$ 4,917,107	$ (1,251,726)	$ 4,577,684	$ 5,632,798	$ (2,306,840)	$ 4,577,684	$ 5,052,628	$ (2,781,785)	$ 4,577,684	$ 5,437,535	$ (3,641,635)	$ 4,577,684	$ 5,021,815	$ (4,085,766)	$ 4,577,684	$ 5,522,472	$ (5,030,555)
CSW,MF&MHC	$ 64,819	$ 5,192	$ 4,297,491	$ 3,000,567	$ 1,356,550	$ 984,316	$ 2,532,503	$ (191,636)	$ 4,297,491	$ 3,083,267	$ 1,022,588	$ 984,316	$ 2,444,712	$ (437,808)	$ 4,297,491	$ 3,064,463	$ 795,219	$ 984,316	$ 2,482,900	$ (703,365)
Dentistry	$ (2,547,240)	$ -	$ 596,212	$ 3,378,618	$ (5,329,646)	$ 5,193,842	$ 3,922,173	$ (4,057,978)	$ 596,212	$ 3,471,737	$ (6,933,503)	$ 5,193,842	$ 3,786,210	$ (5,525,870)	$ 596,212	$ 3,450,565	$ (8,380,223)	$ 5,193,842	$ 3,845,352	$ (7,031,733)
Dental Hygienist	$ 1,534,566	$ 122,929	$ 123,361	$ 421,087	$ 1,113,912	$ 1,269,991	$ 655,576	$ 1,728,326	$ 123,361	$ 432,692	$ 1,418,995	$ 1,269,991	$ 632,850	$ 2,056,136	$ 123,361	$ 430,054	$ 1,749,443	$ 1,269,991	$ 642,736	$ 2,376,698
Dental Labs	$ 357,216	$ 28,615	$ 16,618	$ 38,199	$ 307,020	$ 164,218	$ 69,190	$ 402,048	$ 16,618	$ 39,252	$ 379,414	$ 164,218	$ 66,792	$ 476,840	$ 16,618	$ 39,012	$ 454,446	$ 164,218	$ 67,835	$ 550,829
Dietetics & Nutrition	$ 493,887	$ 39,564	$ 506,142	$ 224,640	$ 735,825	$ 117,242	$ 298,145	$ 554,921	$ 506,142	$ 230,832	$ 830,231	$ 117,242	$ 287,810	$ 659,663	$ 506,142	$ 229,424	$ 936,380	$ 117,242	$ 292,306	$ 761,316
Electrolysis	$ (1,132,509)	$ -	$ 101,588	$ 343,503	$ (1,374,424)	$ 305,838	$ 389,767	$ (1,458,353)	$ 101,588	$ 352,970	$ (1,709,736)	$ 305,838	$ 376,255	$ (1,780,153)	$ 101,588	$ 350,818	$ (2,029,383)	$ 305,838	$ 382,133	$ (2,105,678)
EMS (EMT & PMT)	$ (5,268,243)	$ -	$ 2,554,842	$ 1,811,064	$ (4,524,465)	$ 262,867	$ 1,457,083	$ (5,718,682)	$ 2,554,842	$ 1,860,979	$ (5,024,819)	$ 262,867	$ 1,406,573	$ (6,168,525)	$ 2,554,842	$ 1,849,630	$ (5,463,313)	$ 262,867	$ 1,428,545	$ (6,628,991)
Hearing Aid Specialist	$ 398,838	$ 31,949	$ 455,430	$ 214,536	$ 607,783	$ 59,805	$ 164,830	$ 502,758	$ 455,430	$ 220,449	$ 737,740	$ 59,805	$ 159,117	$ 638,428	$ 455,430	$ 219,104	$ 874,754	$ 59,805	$ 161,602	$ 772,957
Massage Therapy	$ (12,832,570)	$ -	$ 2,042,517	$ 6,092,463	$ (16,882,516)	$ 4,978,017	$ 6,583,768	$ (18,488,266)	$ 2,042,517	$ 6,260,378	$ (22,706,128)	$ 4,978,017	$ 6,355,539	$ (24,083,650)	$ 2,042,517	$ 6,222,199	$ (28,263,332)	$ 4,978,017	$ 6,454,816	$ (29,740,131)
Medical Physicists	$ 212,028	$ 16,985	$ 141,116	$ 47,255	$ 288,904	$ 45,626	$ 36,389	$ 298,142	$ 141,116	$ 48,557	$ 390,700	$ 45,626	$ 35,128	$ 401,199	$ 141,116	$ 48,261	$ 494,054	$ 45,626	$ 35,676	$ 504,004
Medicine	$ 15,468,222	$ 1,239,104	$ 20,210,288	$ 17,422,666	$ 17,016,741	$ 20,210,288	$ 18,052,829	$ 19,174,200	$ 20,210,288	$ 17,902,855	$ 21,481,633	$ 20,210,288	$ 17,427,021	$ 24,264,900	$ 20,210,288	$ 17,793,674	$ 26,681,513	$ 20,210,288	$ 17,699,241	$ 29,192,560
Midwifery	$ (821,861)	$ -	$ 21,767	$ 56,624	$ (856,718)	$ 118,017	$ 98,849	$ (837,549)	$ 21,767	$ 58,184	$ (873,966)	$ 118,017	$ 95,422	$ (851,372)	$ 21,767	$ 57,829	$ (887,434)	$ 118,017	$ 96,913	$ (866,330)
Nursing	$ 10,733,529	$ 859,825	$ 20,424,462	$ 18,716,263	$ 11,581,902	$ 20,424,462	$ 19,083,620	$ 12,922,744	$ 20,424,462	$ 19,236,653	$ 14,110,552	$ 20,424,462	$ 18,416,360	$ 16,118,654	$ 20,424,462	$ 19,118,333	$ 17,424,783	$ 20,424,462	$ 18,706,612	$ 19,142,632
Nursing Home Admin	$ 615,874	$ 49,335	$ 707,058	$ 266,873	$ 1,006,723	$ 195,033	$ 254,687	$ 947,069	$ 707,058	$ 274,229	$ 1,379,898	$ 195,033	$ 245,859	$ 1,329,072	$ 707,058	$ 272,556	$ 1,763,574	$ 195,033	$ 249,699	$ 1,708,908
Occupational Therapy	$ 316,729	$ 25,372	$ 1,186,529	$ 762,020	$ 715,866	$ 375,084	$ 633,719	$ 457,231	$ 1,186,529	$ 783,022	$ 860,738	$ 375,084	$ 611,751	$ 624,072	$ 1,186,529	$ 778,247	$ 1,032,354	$ 375,084	$ 621,307	$ 786,131
Opticianry	$ (441,343)	$ -	$ 561,782	$ 531,618	$ (411,179)	$ 93,372	$ 527,878	$ (845,684)	$ 561,782	$ 546,270	$ (830,172)	$ 93,372	$ 509,578	$ (1,246,378)	$ 561,782	$ 542,938	$ (1,227,535)	$ 93,372	$ 517,538	$ (1,651,701)
Optometry	$ 1,347,082	$ 107,910	$ 1,153,383	$ 497,048	$ 1,895,507	$ 106,908	$ 277,773	$ 1,724,642	$ 1,153,383	$ 510,747	$ 2,367,278	$ 106,908	$ 268,144	$ 2,206,041	$ 1,153,383	$ 507,632	$ 2,851,792	$ 106,908	$ 272,333	$ 2,686,367
Ortho & Proth	$ 593,764	$ 47,564	$ 77,476	$ 86,038	$ 537,637	$ 340,766	$ 138,675	$ 739,728	$ 77,476	$ 88,410	$ 728,795	$ 340,766	$ 133,868	$ 935,693	$ 77,476	$ 87,870	$ 925,299	$ 340,766	$ 135,959	$ 1,130,106
Osteopathic	$ 4,298,096	$ 344,305	$ 676,817	$ 1,432,927	$ 3,197,681	$ 4,073,287	$ 2,214,362	$ 5,056,606	$ 676,817	$ 1,472,420	$ 4,261,003	$ 4,073,287	$ 2,137,601	$ 6,196,689	$ 676,817	$ 1,463,440	$ 5,410,066	$ 4,073,287	$ 2,170,991	$ 7,312,362
Pharmacy	$ 299,380	$ 23,982	$ 6,891,090	$ 7,956,696	$ (790,209)	$ 8,462,300	$ 8,552,899	$ (880,807)	$ 6,891,090	$ 8,175,992	$ (2,165,710)	$ 8,462,300	$ 8,256,409	$ (1,959,819)	$ 6,891,090	$ 8,126,131	$ (3,194,860)	$ 8,462,300	$ 8,385,379	$ (3,117,939)
Physical Therapy	$ 1,372,749	$ 109,966	$ 534,655	$ 1,386,755	$ 410,683	$ 2,678,075	$ 1,669,134	$ 1,419,623	$ 534,655	$ 1,424,976	$ 529,302	$ 2,678,075	$ 1,611,273	$ 1,596,104	$ 534,655	$ 1,416,286	$ 714,474	$ 2,678,075	$ 1,636,442	$ 1,756,107
Physician Assistant	$ 5,009,090	$ 401,260	$ 329,661	$ 1,061,333	$ 3,876,157	$ 4,448,236	$ 1,492,803	$ 6,831,590	$ 329,661	$ 1,090,585	$ 6,070,666	$ 4,448,236	$ 1,441,054	$ 9,077,847	$ 329,661	$ 1,083,934	$ 8,323,574	$ 4,448,236	$ 1,463,564	$ 11,308,245
Podiatry	$ 649,475	$ 52,027	$ 86,734	$ 351,134	$ 333,048	$ 717,769	$ 454,126	$ 596,691	$ 86,734	$ 360,812	$ 322,613	$ 717,769	$ 438,383	$ 601,998	$ 86,734	$ 358,612	$ 330,121	$ 717,769	$ 445,231	$ 602,659
Psychology	$ 2,538,336	$ 203,337	$ 201,619	$ 577,211	$ 1,959,407	$ 1,348,844	$ 531,105	$ 2,777,147	$ 201,619	$ 593,119	$ 2,385,646	$ 1,348,844	$ 512,694	$ 3,221,797	$ 201,619	$ 589,502	$ 2,833,913	$ 1,348,844	$ 520,702	$ 3,662,055
Radiological Tech	$ (254,455)	$ -	$ 968,512	$ 887,916	$ (173,859)	$ 950,512	$ 990,891	$ (214,238)	$ 950,512	$ 912,388	$ (176,114)	$ 950,512	$ 956,541	$ (182,143)	$ 950,512	$ 906,824	$ (138,455)	$ 950,512	$ 971,483	$ (159,425)
Respiratory Therapy	$ 206,440	$ 16,537	$ 839,898	$ 792,788	$ 237,013	$ 206,978	$ 702,466	$ (258,475)	$ 1,621,808	$ 814,638	$ 548,694	$ 206,978	$ 678,114	$ 77,558	$ 1,621,808	$ 809,670	$ 889,696	$ 206,978	$ 688,707	$ 407,967
School Psychology	$ 124,041	$ 9,936	$ 26,666	$ 100,871	$ 39,899	$ 193,706	$ 112,088	$ 121,518	$ 26,666	$ 103,651	$ 44,532	$ 193,706	$ 108,202	$ 130,036	$ 26,666	$ 103,019	$ 53,683	$ 193,706	$ 109,893	$ 137,496
Speech-Language	$ 1,687,610	$ 135,188	$ 441,822	$ 655,164	$ 1,339,080	$ 1,436,357	$ 882,380	$ 1,893,057	$ 441,822	$ 673,221	$ 1,661,658	$ 1,436,357	$ 851,792	$ 2,246,223	$ 441,822	$ 669,115	$ 2,018,930	$ 1,436,357	$ 865,098	$ 2,590,189
Telehealth Providers	$ (164,847)	$ -	$ -	$ 165,000	$ (329,847)	$ -	$ 164,992	$ (494,839)	$ -	$ 165,000	$ (659,839)	$ -	$ 164,992	$ (824,831)	$ -	$ 165,000	$ (989,831)	$ -	$ 164,991	$ (1,154,822)
Total	$ 28,631,262	$ 4,246,171	$ 72,896,701	$ 76,792,856	$ 20,488,935	$ 88,564,162	$ 81,317,272	$ 27,735,826	$ 73,660,611	$ 78,909,358	$ 22,487,079	$ 88,564,162	$ 78,498,378	$ 32,552,863	$ 73,660,611	$ 78,428,130	$ 27,785,343	$ 88,564,162	$ 79,724,569	$ 36,624,936
		84.92%		$ 73,928,876			$ 78,704,306													
							$ 158,110,128													
Unlicensed Activity, NICA, and PRN Project are not included in the above projections.							$ 152,633,181													
Total Cash Sweep is $5,000,000																				

Cash Sweep	$ 5,000,000		
Cash Balance 7/1/2017			Cash Sweep
Licensed	$ 28,631,262	84.92%	$ 4,246,171
Unlicensed	$ 5,082,948	15.08%	$ 753,829
Total MQA TF	$ 33,714,210	100.00%	$ 5,000,000

	ENDING ULA CASH BAL 6/30/2020	ALLOCATION OF CASH WITHDRAWAL	ULA IMPACT CASH BAL 6/30/2018
MQA TRUST FUND			
Acupuncture	**$ (847)**	**$ -**	**$ (847)**
Anesthesiologist Asst	**$ 2,960**	**$ 153**	**$ 2,807**
Athletic Trainers	**$ 38,079**	**$ 1,964**	**$ 36,115**
Chiropractic	**$ 76,241**	**$ 3,932**	**$ 72,309**
Clinical Lab	**$ 264,823**	**$ 13,657**	**$ 251,166**
Cert Nurs Asst	**$ 1,985,470**	**$ 102,392**	**$ 1,883,078**
Cert Social Worker		**$ -**	**$ -**
CSW,MF&MHC	**$ 254,823**	**$ 13,141**	**$ 241,682**
Dentistry	**$ (1,134,745)**	**$ -**	**$ (1,134,745)**
Dental Hygienist	**$ 256,081**	**$ 13,206**	**$ 242,875**
Dental Labs	**$ (243,551)**	**$ -**	**$ (243,551)**
Dietetics & Nutrition	**$ (275,569)**	**$ -**	**$ (275,569)**
Electrolysis	**$ (358,879)**	**$ -**	**$ (358,879)**
EMS (EMT & PMT)	**$ (18,414)**	**$ -**	**$ (18,414)**
Hearing Aid Specialist	**$ (98,282)**	**$ -**	**$ (98,282)**
Massage Therapy	**$ (3,757,762)**	**$ -**	**$ (3,757,762)**
Medical Physicists	**$ 13,232**	**$ 682**	**$ 12,550**
Medicine	**$ (2,362,620)**	**$ -**	**$ (2,362,620)**
Midwifery	**$ (104,411)**	**$ -**	**$ (104,411)**
Naturopathic		**$ -**	**$ -**
Nursing	**$ 9,241,248**	**$ 476,575**	**$ 8,764,673**
Nursing Home Admin	**$ 28,213**	**$ 1,455**	**$ 26,758**
Occupational Therapy	**$ 299,424**	**$ 15,441**	**$ 283,983**
Opticianry	**$ (894,495)**	**$ -**	**$ (894,495)**
Optometry	**$ 34,773**	**$ 1,793**	**$ 32,980**
Ortho & Proth	**$ (144,780)**	**$ -**	**$ (144,780)**
Osteopathic	**$ 115,783**	**$ 5,971**	**$ 109,812**
Pharmacy	**$ 691,368**	**$ 35,654**	**$ 655,714**
Physical Therapy	**$ 498,027**	**$ 25,683**	**$ 472,344**
Physician Assistant	**$ 162,819**	**$ 8,397**	**$ 154,422**
Podiatry	**$ 30,774**	**$ 1,587**	**$ 29,187**
Psychology	**$ (139,492)**	**$ -**	**$ (139,492)**
Radiological Tech	**$ (671)**	**$ -**	**$ (671)**
Respiratory Therapy	**$ 318,237**	**$ 16,412**	**$ 301,825**
School Psychology	**$ 14,221**	**$ 733**	**$ 13,488**
Speech-Language	**$ 290,870**	**$ 15,000**	**$ 275,870**
Telehealth Providers	**$ -**		
Total	**$ 5,082,948**	**$ 753,829**	**$ 4,329,119**

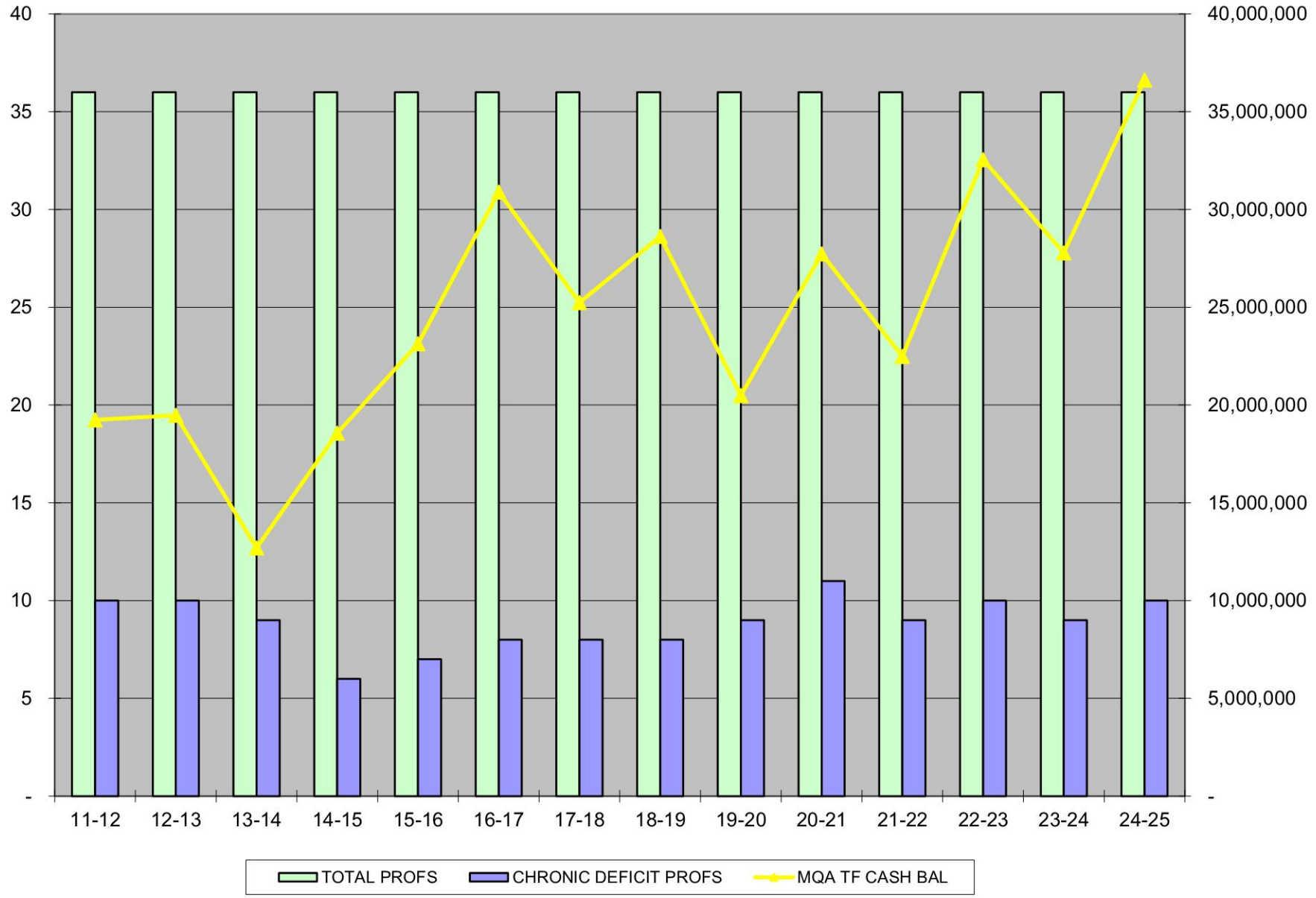
NICA is not included in the above cash balance.

	Actual	Actual	Actual
	Cash Balance	Cash Balance	Cash Balance
MQA TRUST FUND	**11-12**	**12-13**	**13-14**
TOTAL PROFS	36	36	36
CHRONIC DEFICIT PROFS	10	10	9
MQA TF CASH BAL	19,247,101	19,475,305	12,699,433
%OFDEFICIT PROFESSIONS	27.8%	27.8%	25.0%

Actual	Actual	Actual	Actual	Actual
Cash Balance	Cash Balance	Cash Balance	Cash Balance	Cash Balance
14-15	15-16	16-17	17-18	18-19
36	36	36	36	36
6	7	8	8	8
18,568,204	23,135,314	30,898,177	25,245,613	28,631,262
16.7%	19.4%	22.2%	22.2%	22.2%

Projected Cash Balance 19-20	Projected Cash Balance 20-21	Projected Cash Balance 21-22	Projected Cash Balance 22-23	Projected Cash Balance 23-24
36	36	36	36	36
9	11	9	10	9
20,488,935	27,735,826	22,487,079	32,552,863	27,785,343
25.0%	30.6%	25.0%	27.8%	25.0%

Projected Cash Balance 24-25
36
10
36,624,936
27.8%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TOTAL PROFS
CHRONIC DEFICIT PROFS
MQA TF CASH BAL

TO: Board of Opticianry

FROM: Janet Hartman, Executive Director

SUBJECT: Annual Delegation of Authority

DATE: October 23, 2020

The table below reflects the delegated authority to conduct specified tasks as directed by the Board of Opticianry.

Situation	Delegate Authority to Board Chair	Delegate Authority to Full Board	Delegate Authority to Committee or Liaison	Delegate Authority to Executive Director	Delegate Authority to Board Counsel
Authority to grant continuances.	X				
Authority to grant temporary approval of monitors if required by Final Order.	X				
Authority to require a PRN evaluation.		X			
Authority to require a personal appearance pursuant to 456.013(3)(c), F.S.	X				
Authority to sign orders of the Board on behalf of the Chair.				X	
Authority to grant temporary approval of CE courses, etc. required in disciplinary cases.			X		
Authority to grant extension requests for payment of fines/costs or completion of CME, etc, resulting from discipline.	(2nd and thereafter)			Executive Director (1st time)	
Authority to review and refer legally sufficient petitions for declaratory statements to the Board. Authority to notify petitioners, by letter, of the need to submit any required additional information prior to consideration by the Board.					X

Situation	Delegate Authority to Board Chair	Delegate Authority to Full Board	Delegate Authority to Committee or Liaison	Delegate Authority to Executive Director	Delegate Authority to Board Counsel
Authority to review and refer legally sufficient petitions for variances or waivers to the Board. Authority to notify petitioners, by letter, of legally insufficient petitions.					X
Authority to review requests for DOAH hearings in licensure cases and refer to DOAH when appropriate.					X
Authority to make technical changes to proposed rules and respond to JAPC comments, without Board review. Substantive changes will be brought to the Board before changes are made.					X
Authority to approve applicants for licensure that meet the statutory and rule requirements.				Executive Director and Board Staff	
Authority to apply the Conviction Record Guidelines (CRG) approved by the Board when reviewing criminal history.				Executive Director and Board Staff	
Authority to review applications, referred by staff, to determine if review by full Board is required.			Board Committee Member(s) Only		
Authority to approve continuing education providers.		X			
Authority to approve continuing education courses.			Board Committee Member(s) Only		
Authority to conduct annual CE Broker review.				Executive Director and Board Staff	
Authority to direct audits or monitoring of continuing education courses and providers.	X				

The above-referenced delegations were authorized by unanimous vote of the Board of Opticianry on October 23, 2020 and will remain effective until modified by the Board.

_____ _____

John B. Girdler III **Date**
Board Chair

DEPARTMENT OF HEALTH				
BOARD OF OPTICIANRY				
EXPENDITURES BY FUNCTION				
For Period Ending June 30, 2020				
	Direct	**Allocated**		
Function	**Charges**	**Charges**	**Total**	**Percent***
Director, MQA		$ 8,306	$ 8,306	1.23%
Bureau of Opns Admin		$ 2,901	$ 2,901	0.43%
Testing Services			$ -	0.00%
Licensure Support Svcs	$ 1,108	$ 4,277	$ 5,385	0.80%
Artificial Intelligence		$ 1,645	$ 1,645	0.24%
Practitioner Reporting		$ 130	$ 130	0.02%
Systems Spt Unit		$ 31,349	$ 31,349	4.66%
Central Records		$ 4,216	$ 4,216	0.63%
Renewal Support			$ -	0.00%
Call Center		$ 17,902	$ 17,902	2.66%
Operational Services		$ 11,971	$ 11,971	1.78%
Imaging Services		$ 16,727	$ 16,727	2.48%
Web Design Development		$ 5,100	$ 5,100	0.76%
Strategic Management Unit		$ 5,496	$ 5,496	0.82%
Background Screening	$ 8		$ 8	0.00%
Bureau of HCPR Admin		$ 5,528	$ 5,528	0.82%
Board Office	$ 82,164	$ 116,294	$ 198,458	29.48%
Prosecution Svcs Unit - Enforce	$ 1,308	$ 22,875	$ 24,183	3.59%
Bureau of Enforce Admin		$ 1,880	$ 1,880	0.28%
Consumer/Compliance Unit - Enforce		$ 2,877	$ 2,877	0.43%
Investigations Svcs Unit-Enforce	$ 389	$ 96,221	$ 96,610	14.35%
Div of IT & Admin; Ofc of Sec		$ 38,800	$ 38,800	5.76%
DOAH			$ -	0.00%
Profiling Services			$ -	0.00%
Practitioner Compliance			$ -	0.00%
Impaired Practitioner		$ 2,875	$ 2,875	0.43%
Attorney General	$ 19,381		$ 19,381	2.88%
Risk Management Insurance		$ 4,686	$ 4,686	0.70%
Human Resource Services		$ 1,386	$ 1,386	0.21%
Refund of State Revenues	$ 665	$ 1	$ 666	0.10%
Service Charge to Gen Revenue	$ 10,213	$ 0	$ 10,214	1.52%
FDLE Transfer			$ -	0.00%
Ch 215.32 Transfer of Funds			$ -	0.00%
			$ -	
Unlicensed Activity	$ 816	$ 153,671	$ 154,486	22.95%
ULA Ch 215.32 Transfer of Funds			$ -	0.00%

			$ -	
Total	$ 116,051.84	$ 557,114.40	$ 673,166.24	100.00%
Cash Balance @ June 30 - Licensed Account				$ (441,341)
Cash Balance @ June 30 - Unlicensed Account				$ (894,495)
* Percent of the function's expenditure to the Board's total expenditures.				

64B12-9.001 Examination for Licensure.

(1) Both the American Board of Opticianry and National Contact Lens Examiners (ABO-NCLE) and National Commission of State Opticianry Regulatory Boards (NCSORB) examinations~~, each composed of two parts,~~ are considered state board approved practical examinations for the purposes of this section.

(2) There shall be three parts to the examination for Florida ~~L~~licensure in opticianry:

(a) ~~a~~A national opticianry competency examination which shall consist of either the National Opticianry Competency Examination developed by the American Board of Opticianry (ABO) or the Basic Spectacles Examination developed by NCSORB;

(b) ~~a~~A national contact lens examination which shall consist of either Contact Lens Registry Examination developed by the National Contact Lens Examiners (NCLE) or the Basic Contact Lens Examination developed by NCSORB; and

(c) ~~a~~ A state board approved practical examination.

~~(3) The national opticianry competency examination portion of the examination shall be either the National Opticianry Competency Examination developed by the American Board of Opticianry. This portion of the licensure examination shall be completed through the American Board of Opticianry, and proof of successful completion shall be required prior to a candidate's taking a state board approved examination.~~

~~(4) The national contact lens examination portion of the examination shall be the Contact Lens Registry Examination developed by the National Contact Lens Examiners. This portion of the licensure examination shall be completed through the National Contact Lens Examiners, and proof of successful completion shall be required prior to a candidate's taking a state board approved examination.~~

~~(5) The criteria for determining the minimum score necessary for passing the National Opticianry Competency Examination and the Contact Lens Registry Examination and a state board approved practical examination, shall be developed through the collective judgment of qualified experts appointed by the "American Board of Opticianry" to set the score that represents the minimum amount of knowledge necessary to pass the examination. The state board approved practical examination shall be scored using the criterion-referenced passing score established by the organization administering the exam.~~

~~(6) Proof of having successfully completed the national portions of the examination shall consist of certification of the candidate's scores from the testing body directly to the Board. It is the candidate's responsibility to arrange for transfer of scores. The scores shall reflect that the candidate successfully completed the examinations within the three years preceding application for licensure. If however, the candidate successfully completed the examinations and has maintained a current certificate by having completed continuing education courses, the Board shall accept a copy of the original certificate of National Certification.~~

(3~~7~~) Applicants, who have been certified eligible by the board, having completed all requirements including successful completion of the opticianry competency and the contact lens examinations, will be admitted to take a state board approved practical examination.

(4) Proof of successful completion of the examinations shall consist of certification of the candidate's scores from the testing body directly to the Board.

(5) The respective testing body shall establish the criteria for determining the minimum score necessary for successful completion.

(6) The applicant must have successfully completed all required examinations within the three years immediately preceding application for licensure. For applications submitted more than three years after successful completion of the examinations, the applicant may submit a current National Certification and proof that the applicant has continued to maintain a current National Certification by completing continuing education courses.

Rulemaking Authority 456.017(1), 484.005 FS. Law Implemented 456.017(1) FS. History–New 12-6-79, Amended 8-10-80, 3-11-81, 10-29-81, 6-30-82, 8-11-82, 2-2-83, 8-29-85, Formerly 21P-9.01, Amended 9-17-87, 3-30-89, 2-18-93, Formerly 21P-9.001, Amended 5-2-94, Formerly 61G13-9.001, Amended 5-4-97, Formerly 59U-9.001, Amended 4-20-98, 9-12-99, 1-7-03, 8-28-05, 7-12-07, 5-16-12, 7-23-19,_____.

DRAFT

64B12-9.001 Examination for Licensure.

(1) Both the American Board of Opticianry and National Contact Lens Examiners (ABO-NCLE) and National Commission of State Opticianry Regulatory Boards (NCSORB) examinations are considered state board approved practical examinations for the purposes of this section.

(2) There shall be three parts to the examination for Florida licensure in opticianry:

(a) A national opticianry competency examination which shall consist of either the National Opticianry Competency Examination developed by the American Board of Opticianry (ABO) or the Basic Spectacles Examination developed by NCSORB;

(b) A national contact lens examination which shall consist of either Contact Lens Registry Examination developed by the National Contact Lens Examiners (NCLE) or the Basic Contact Lens Examination developed by NCSORB; and

(c) A state board approved practical examination.

(3) Applicants, who have been certified eligible by the board, having completed all requirements including successful completion of the opticianry competency and the contact lens examinations, will be admitted to take a state board approved practical examination.

(4) Proof of successful completion of the examinations shall consist of certification of the candidate's scores from the testing body directly to the Board.

(5) The respective testing body shall establish the criteria for determining the minimum score necessary for successful completion.

(6) The applicant must have successfully completed all required examinations within the three years immediately preceding application for licensure. For applications submitted more than three years after successful completion of the examinations, the applicant may submit a current National Certification and proof that the applicant has continued to maintain a current National Certification by completing continuing education courses.

Rulemaking Authority 456.017(1), 484.005 FS. Law Implemented 456.017(1) FS. History–New 12-6-79, Amended 8-10-80, 3-11-81, 10-29-81, 6-30-82, 8-11-82, 2-2-83, 8-29-85, Formerly 21P-9.01, Amended 9-17-87, 3-30-89, 2-18-93, Formerly 21P-9.001, Amended 5-2-94, Formerly 61G13-9.001, Amended 5-4-97, Formerly 59U-9.001, Amended 4-20-98, 9-12-99, 1-7-03, 8-28-05, 7-12-07, 5-16-12, 7-23-19,_____.

BILL GALVANO
President

JOSE R. OLIVA
Speaker

THE FLORIDA LEGISLATURE

JOINT ADMINISTRATIVE PROCEDURES COMMITTEE

Senator Linda Stewart, Chair
Representative Erin Grall, Vice Chair
Senator Janet Cruz
Senator Ed Hooper
Senator Keith Perry
Senator Tom A. Wright
Representative Vance Arthur Aloupis, Jr.
Representative Tommy Gregory
Representative Cindy Polo
Representative Holly Raschein
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Representative Clovis Watson, Jr.

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COORDINATOR
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September 8, 2020

Mr. Timothy Frizzell
Assistant Attorney General
Office of the Attorney General
PL-01, The Capitol
Tallahassee, Florida 32399-1050

RE: Department of Health: Board of Opticianry
Proposed Rules 64B12-8.020 and .024

Dear Mr. Frizzell:

I have reviewed the above-referenced proposed rules, which were advertised in the Florida Administrative Register on September 3, 2020. I have the following comments.

64B12-8.020: It appears that section 456.47(7) should be added as rulemaking authority.

It appears that section 456.47(4) should be added as a law implemented.

64B12-8.024(1): The paragraphs of this rule subsection are improperly designated. Please correct paragraphs (1)1., 2., 3., and 4. to (1)(a), (b), (c), and (d).

64B12-8.024(1)1. [*sic*]: It does not appear necessary to include the language "applicable" and "of the department if there is no board" in the description of this violation.

64B12-8.024(1)4. [*sic*]: It does not appear this violation should refer to section 465.016(1). Please correct this citation; perhaps the board intended to refer instead to section 484.014.

64B12-8.024(2): It appears that the comma following "severity" should be a colon.

Please let me know if you have any questions. Otherwise, I look forward to your response.

Sincerely,

Marjorie C. Holladay
Chief Attorney

cc: Mr. Edward A. Tellechea, Chief Assistant Attorney General

MH:df #182711_182712

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ATTORNEY GENERAL
STATE OF FLORIDA

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September 10, 2020

Ms. Marjorie C. Holladay
Chief Attorney
Joint Administrative Procedures Committee
Room 680, Pepper Building
111 W. Madison Street
Tallahassee, FL 32399

Re: **Department of Health: Board of Opticianry**
Proposed Rules 64B12-8.020, and .024

Dear Ms. Holladay:

The Board of Opticianry ("Board") is in receipt of your September 8, 2020, letter with included comments regarding the Board's existing rules 64B12-8.020 and .024, F.A.C. Your comments will need to be addressed by the full board at a regularly scheduled board meeting. I have the following response to same:

64B12-8.020: I agree that section 456.47(7) should be added as rulemaking authority and that section 456.47(4) should be added as law implemented.

64B12-8.024: I agree with your request to correct paragraphs (1)1., 2., 3, and 4. to (1)(a), (b), (c) and (d).

64B12-8.024(1)(a): I agree with your suggestion that the language "applicable" and "or the department if there is no board" is not necessary in the description of this violation.

64B12-8.024(1)(d): You are correct that the board intended to refer to section 484.014 rather than section 465.016(1).

64B12-8.024(2): I agree that the comma following "severity" should be a colon.

We will proceed accordingly to effect the above noted corrections and changes. Please do not hesitate to contact me should you have any questions or concerns regarding this matter.

Sincerely,

/s Timothy Frizzell
Timothy Frizzell
Assistant Attorney General
Timothy.Frizzell@myfloridalegal.com

cc: Edward Tellechea, Bureau Chief
Janet Hartman, Executive Director
Tracy Smith, Paralegal Specialist

64B12-8.020 Disciplinary Guidelines.

(1) The Board provides within this rule disciplinary guidelines which shall be imposed upon applicants or licensees whom it regulates under Chapter 484, F.S., or a telehealth provider registered under section 456.47(4), F.S.. The purpose of this rule is to notify applicants and licensees of the ranges of penalties that will routinely be imposed unless the Board finds it necessary to deviate from the guidelines for the stated reasons given within this rule. The ranges of penalties provided below are based upon a single count violation of each provision listed; multiple counts of the violated provisions or a combination of the violations may result in a higher penalty than that for a single, isolated violation. Each range includes the lowest and highest penalty and all penalties falling between. The purposes of the imposition of discipline are to punish the applicants or licensees for violations and to deter them from future violations; to offer opportunities for rehabilitation, when appropriate; and to deter other applicants or licensees from violations.

(2) No Change.

(3) When the Board finds an applicant or licensee whom it regulates under Chapter 484, F.S., or a telehealth provider registered under section 456.47(4), F.S., has committed any of the acts set forth in Sections 456.072, 456.47, or 484.014, F.S., it shall issue a final order imposing appropriate penalties within the ranges recommended in the following disciplinary guidelines:

VIOLATIONS	RECOMMENDED PENALTIES			TELEHEALTH DISCIPLINE	
	First Offense	Second Offense	Third and subsequent Offenses	First Offense	Second and Subsequent Offenses
(a) Procuring or attempting to procure, or renew a license by misrepresentation, bribery, fraud or through an error of the Department or the Board. (Section 484.014(1)(a), F.S.) (Section 456.072(1)(h), F.S.)	~~(a) From~~ R~~r~~eprimand to probation of the license and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an application for licensure. If the violation is for fraud or making a false or fraudulent representation, the administrative fine is $10,000.00.	~~(a) From~~ S~~s~~uspension to revocation of the license and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure. If the violation is for fraud or making a false or fraudulent representation, the administrative fine is $10,000.00.	~~(a) From~~ R~~r~~evocation, without the ability to reapply, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure. If the violation is for fraud or making a false or fraudulent representation, the administrative fine is $10,000.00.	Reprimand to suspension and a corrective action plan	Suspension to revocation
(b) Procuring or attempting to procure a license for any other person by making or causing to be made any false representation.	~~(b) From~~ R~~r~~eprimand to probation of the license, and an administrative fine ranging from $250.00	~~(b) From~~ P~~p~~robation to suspension of the license, and an administrative fine ranging from $500.00	~~(b) From~~ S~~s~~uspension to revocation, without the ability to reapply, and an administrative	Reprimand to suspension and a corrective action plan	Suspension and a corrective action plan to revocation

(Section 484.014(1)(b), F.S.)	to $500.00, or refusal to certify an application for licensure. If the violation is for fraud or making a false or fraudulent representation, the administrative fine is $10,000.00.	to $750.00, or refusal to certify an application for licensure. If the violation is for fraud or making a false or fraudulent representation, the administrative fine is $10,000.00.	fine of $1,000.00, or refusal to certify an application for licensure. If the violation is for fraud or making a false or fraudulent representation, the administrative fine is $10,000.00.		
(c) Filing a false report or failing to file a report as required. Such reports or records shall include only those which the person is required to make or file as an optician. (Section 484.014(1)(c), F.S.) (Section 456.072(1)(l), F.S.)	~~(c) From a~~ L~~l~~etter of concern to reprimand of the license, and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an application for licensure.	~~(c) From~~ P~~p~~robation to suspension of the license and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	~~(c) From~~ S~~s~~uspension to revocation of the license, and an administrative fine ranging from $750.00 to $1000.00, or refusal to certify an application for licensure.	Letter of concern to reprimand	Suspension and a corrective action plan to revocation
(d) Failing to make fee or price information readily available by providing such information upon request or upon the presentation of a prescription. (Section 484.014(1)(d), F.S.)	~~(d) From a~~ L~~l~~etter of concern to reprimand of the license, and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an application for licensure.	~~(d) From~~ R~~r~~eprimand to probation of the license, and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	~~(d) From~~ P~~p~~robation to suspension of the license, and an administrative fine ranging from $750.00 to $1000.00, or refusal to certify an application for licensure.	Letter of concern to reprimand	Reprimand to suspension
(e) False, deceptive, or misleading advertising. (Section 484.014(1)(e), F.S.)	~~(e) From a~~ L~~l~~etter of concern to probation of the license, and an administrative fine ranging from $250.00 to $500.00, or refusal	~~(e) From~~ P~~p~~robation to suspension of the license, and an administrative fine ranging from $500.00	~~(e) From~~ S~~s~~uspension to revocation of the license, and an administrative fine ranging from $750.00	Letter of concern to suspension and a corrective action plan	Suspension and a corrective action plan to revocation

	to certify an application for licensure.	to $750.00, or refusal to certify an application for licensure.	to $1,000.00, or refusal to certify an application for licensure.		
(f) Fraud or deceit, or negligence, incompetency, or misconduct in the authorized practice of opticianry. (Section 484.014(1)(f), F.S.)	~~(f) From~~ ~~R~~reprimand to probation of the license, and an administrative fine ranging from $1,000.00 to $3,000.00, and if fraud is proven, an administrative fine of $10,000.00, or refusal to certify an application for licensure.	~~(f) From~~ ~~P~~probation to suspension of the license, and an administrative fine ranging from $3,000.00 to $5,000.00, and if fraud is proven, an administrative fine of $10,000.00, or refusal to certify an application for licensure.	~~(f) From~~ ~~S~~suspension to revocation of the license, and an administrative fine ranging from $5,000.00 to $10,000.00, and if fraud is proven, an administrative fine of $10,000.00, or refusal to certify an application for licensure.	Reprimand to suspension and a corrective action plan	Suspension and a corrective action plan to revocation
(g) Practicing with a revoked, suspended, inactive, retired, or delinquent license. (Sections 456.036(1) and 484.014(1)(g), F.S.)	~~(g) From~~ ~~R~~reprimand to probation of the license, and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an application for licensure.	~~(g) From~~ ~~P~~probation to suspension of the license and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	~~(g) From~~ ~~S~~suspension to revocation, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.	Reprimand to suspension and a corrective action plan	Suspension and a corrective action plan to revocation
(h) Violation of a lawful order of the Board or Department or a subpoena of the Department. (Section 484.014(1)(h), F.S.) (Section 456.072(1)(q), F.S.)	~~(h) From a~~ ~~L~~letter of concern to reprimand of the license, and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an application for licensure.	~~(h) From~~ ~~P~~probation to suspension of the license, and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	~~(h) From~~ ~~S~~suspension to revocation of the license, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.	Letter of concern to reprimand	Suspension and a corrective action plan to revocation
(i) Violation of any provision of	~~(i) From~~ ~~R~~reprimand to	~~(i) From~~ ~~P~~probation to	~~(i) From~~ ~~S~~suspension	Reprimand to	Suspension and a

Section 484.012, F.S. (Section 484.014(1)(i), F.S.)	suspension of the license, and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an application for licensure.	suspension, and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	to revocation, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.	suspension	corrective action plan to revocation
(j) Conspiring to restrict another from lawfully advertising his or her services. (Section 484.014(1)(j), F.S.)	~~(j) From~~ R~~r~~eprimand to probation of the license, and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an application for licensure.	~~(j) From~~ P~~p~~robation to suspension of the license, and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	~~(j) From~~ S~~s~~uspension to revocation of the license and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.	Reprimand to suspension and a corrective action plan	Suspension and a corrective action plan to revocation
(k) Willfully submitting to any thirdparty payor a claim for services which were not provided to a patient. (Section 484.014(1)(k), F.S.) The licensee's reimbursement to the third-party payor shall be considered as a mitigating factor by the board.	~~(k) From~~ R~~r~~eprimand to suspension of the license, and an administrative fine ranging from $250.00 to $750.00, or refusal to certify an application for licensure.	~~(k) From~~ P~~p~~robation to suspension, and an administrative fine ranging from $500.00 to $1,000.00, or refusal to certify an application for licensure.	~~(k) From~~ S~~s~~uspension to revocation of the license, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.	Reprimand to suspension	Suspension and a corrective action plan to revocation
(l) Failing to keep written prescription files. (Section 484.014(1)(l), F.S.)	~~(l) From a~~ R~~r~~eprimand to probation of the license, and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an application for licensure.	~~(l) From~~ P~~p~~robation to suspension of the license, and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an	~~(l) From~~ S~~s~~uspension to revocation of the license, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an	Reprimand to suspension and a corrective action plan	Suspension and a corrective action plan to revocation

		application for licensure.	application for licensure.		
(m) Failure to report another licensee in violation of Chapters 484, Part I, 456, F.S., or rule of the Board or Department. (Section 484.014(1)(m), F.S.) (Section 456.072(1)(i), F.S.)	~~(m) From a~~ L~~l~~etter of concern to probation of the license, and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an application for licensure.	~~(m) From~~ P~~p~~robation to suspension of the license, and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	~~(m) From~~ S~~s~~uspension to revocation of the license and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.	Letter of concern to suspension and a corrective action plan	Suspension and a corrective action plan to revocation
(n) Exercising influence on a client for financial gain of the licensee or of a third party. (Section 484.014(1)(n), F.S.) (Section 456.072(1)(n), F.S.)	~~(n) From~~ R~~r~~eprimand to probation of the license, and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an application for licensure.	~~(n) From~~ P~~p~~robation to revocation of the license, and an administrative fine ranging from $500.00 to a $750.00, or refusal to certify an application for licensure.	~~(n) From~~ S~~s~~uspension to revocation and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.	Reprimand to suspension and a corrective action plan	Suspension and a corrective action plan to revocation
(o) Gross or repeated malpractice. (Section 484.014(1)(o), F.S.)	~~(o) From~~ P~~p~~robation to revocation of the license, and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	~~(o) From~~ S~~s~~uspension to revocation of the license, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.	~~(o) From~~ S~~s~~uspension to revocation of the license, without the ability to reapply, and an administrative fine ranging from $900.00 to $1,000.00, or refusal to certify an application for licensure.	Suspension and a corrective action plan to revocation	Suspension to revocation
(p) Permitting any person not licensed as an optician in this state to fit or dispense any	~~(p) From~~ R~~r~~eprimand to probation of the license, and an administrative fine ranging from	~~(p) From~~ P~~p~~robation to suspension of the license, and an administrative	~~(p) From~~ S~~s~~uspension to revocation of the license, and an administrative	Reprimand to suspension and a corrective action plan	Suspension and a corrective action plan to revocation

lenses, spectacles, eyeglasses, or other optical devices that are part of the practice of opticianry. (Section 484.014(1)(p), F.S.)	$250.00 to $500.00, or refusal to certify an application for licensure.	fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.		
(q) Guilty of a crime directly relating to the ability to practice opticianry or to the practice of opticianry. (Section 484.014(1)(q), F.S.) (Section 456.072(1)(c), F.S.)	~~(q) From~~ R~~r~~eprimand to suspension of the license, and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	~~(q) From~~ P~~p~~robation to revocation of the license, and an administrative fine ranging from $500.00 to $1,000.00, or refusal to certify an application for licensure.	~~(q) From~~ S~~s~~uspension to revocation of the license, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.	Reprimand to suspension	Suspension and a corrective action plan to revocation
(r) Action taken against license by another jurisdiction. Licensing authority's acceptance of a relinquishment of licensure, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of charges against the license, shall be construed as action against the license. (Section 484.014(1)(r), F.S.) (Section 456.072(1)(f), F.S.)	~~(r) From~~ R~~r~~eprimand to probation of the license, and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an application for licensure.	~~(r) From~~ P~~p~~robation to suspension of the license, and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	~~(r) From~~ S~~s~~uspension to revocation of the license, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.	Reprimand to suspension and a corrective action plan	Suspsension and a corrective action plan to revocation
(s) Being unable to practice	~~(s) From~~ R~~r~~eprimand to	~~(s) From~~ P~~p~~robation to	~~(s) From~~ S~~s~~uspension	Reprimand to	Suspension and a

opticianry with reasonable skill and safety by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition. (Section 484.014(1)(s), F.S.) (Section 456.072(1)(z), F.S.)	suspension of the license, and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an application for licensure.	revocation of the license, and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	to revocation of the license, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.	suspension and a corrective action plan	corrective action plan to revocation
(t) Violation or repeated violation of Chapter 456 or 484, F.S., or any rules promulgated pursuant thereto. (Section 484.014(1)(i), (t), F.S.) (Section 456.072(1)(b), (dd), F.S.)	~~(t) From~~ R~~r~~eprimand to suspension of the license, and an administrative fine ranging from $250.00 to $750.00, or refusal to certify an application for licensure.	~~(t) From~~ P~~p~~robation to revocation of the license, and an administrative fine ranging from $500.00 to $1,000.00, or refusal to certify an application for licensure.	~~(t) From~~ S~~s~~uspension to revocation of the license, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.	Reprimand to suspension	Suspension and a corrective action plan to revocation

(4) When the Board finds an applicant or licensee whom it regulates under Chapter 484, F.S., or a telehealth provider registered under section 456.47(4), F.S., has violated Section 484.014(1)(t), F.S., by violating any of the following Board rules, it shall issue a final order imposing appropriate penalties within the ranges recommended in the following disciplinary guidelines:

VIOLATIONS	RECOMMENDED PENALTIES			TELEHEALTH DISCIPLINE	
	First Offense	Second Offense	Third and subsequent Offenses	First Offense	Second and Subsequent Offenses
(a) Failure to give notice of withdrawal of services pursuant to Rule 64B12-10.003, F.A.C.	~~(a) From~~ R~~r~~eprimand to probation of the license, and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an	~~(a) From~~ P~~p~~robation to suspension of the license, and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an	~~(a) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for	Reprimand to suspension and a corrective action plan	Suspension and a corrective action plan to revocation

	application for licensure.	application for licensure.	licensure.		
(b) Failure to identify through written notice or orally to a patient the type of license under which the practitioner is practicing pursuant to Rule 64B12-10.0035, F.A.C.	~~(b) From a~~ L~~l~~etter of concern to reprimand of the license, and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an application for licensure.	~~(b) From~~ R~~r~~eprimand to probation of the license, and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	~~(b) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.	Letter of concern to reprimand	Reprimand to revocation
(c) Failure to properly keep and transfer prescription files pursuant to Rule 64B12-10.006, F.A.C.	~~(c) From a~~ L~~l~~etter of concern to reprimand of the license, and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an application for licensure.	~~(c) From~~ R~~r~~eprimand to probation of the license, and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	~~(c) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.	Letter of concern to reprimand	Reprimand to revocation
(d) Failure to assure that duplicate prescription forms contain the information required by Rule 64B12-10.0065, F.A.C.	~~(d) From a~~ L~~l~~etter of concern to reprimand of the license, and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an application for licensure.	~~(d) From~~ R~~r~~eprimand to probation of the license, and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	~~(d) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.	Letter of concern to reprimand	Reprimand to revocation
(e) Failure to maintain the equipment required by Rule 64B12-10.007, F.A.C.	~~(e)~~ Notice of Non-Compliance.	~~(e) From~~ P~~p~~robation to revocation of the license, and an administrative fine ranging from $500.00	~~(e) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $750.00 to $1,000.00,	Letter of concern to reprimand	Suspension and a corrective action plan

		to $750.00, or refusal to certify an application for licensure.	or refusal to certify an application for licensure.		
(f) Failure to provide change of address, pursuant to Rule 64B12-10.012, F.A.C.	~~(f)~~ Notice of Non-Compliance.	~~(f) From~~ R~~r~~eprimand to probation of the license, and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	~~(f) From~~ R~~r~~eprimand to suspension of license, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.	Letter of concern to reprimand	Reprimand to suspension
(g) Failure to properly supervise an apprentice as required by Rule 64B12-16.003, F.A.C. For each offense, depending upon aggravating and mitigating circumstances, the Board may require probation with the condition that the licensee not serve as a sponsor.	~~(g) From a~~ R~~r~~eprimand to probation of the license, and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an application for licensure.	~~(g) From~~ P~~p~~robation to suspension of the license, and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	~~(g) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.	Reprimand to suspension and a corrective action plan	Suspension and a corrective action plan to revocation
(h) Failure to file the proper report upon termination of apprenticeship as required by Rule 64B12-16.004, F.A.C. For each offense, depending upon aggravating and mitigating circumstances, the board may deny credit for hours of apprenticeship.	~~(h) From a~~ R~~r~~eprimand to probation of the license, and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an application for licensure.	~~(h) From~~ P~~p~~robation to suspension of the license, and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	~~(h) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.	Reprimand to suspension and a corrective action plan	Suspension and a corrective action plan to revocation
(i) Failure to file the proper report upon termination of sponsorship as	~~(i) From a~~ R~~r~~eprimand to probation of the license,	~~(i) From~~ P~~p~~robation to suspension of the license,	~~(i) From~~ S~~s~~uspension to revocation of license, and an	Reprimand to suspension and a	Suspension and a corrective action plan

required by Rule 64B12-16.004, F.A.C. Depending upon aggravating and mitigating circumstances for each offense, the Board may require probation with the condition that the licensee not serve as a sponsor.	and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an application for licensure.	and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.	corrective action plan	to revocation
(j) Failure of a sponsor or apprentice to comply with Chapters 484, Part I, and 456, F.S., and the rules of the Board and Department or to timely file complete reports or information as required by Rule 64B12-16.008, F.A.C. Depending upon aggravating and mitigating circumstances for each offense, the Board may require probation with the condition that the licensee not serve as a sponsor or the board may deny credit for hours of apprenticeship.	~~(j) From a~~ R~~r~~eprimand to suspension of the license, and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an application for licensure.	~~(j) From~~ P~~p~~robation to suspension of the license, and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	~~(j) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an application for licensure.	Reprimand to suspension	Suspension and a corrective action plan to revocation
(k) Failure to maintain accurate and complete records of time worked by an apprentice, pursuant to Rule 64B12-16.009, F.A.C.	~~(k) From a~~ R~~r~~eprimand to probation of the license, and an administrative fine ranging from $250.00 to $500.00, or	~~(k) From~~ P~~p~~robation to suspension of the license, and an administrative fine ranging from $500.00 to $750.00, or	~~(k) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to	Reprimand to suspension and a corrective action plan	Suspension and a corrective action plan to revocation

Depending upon aggravating and mitigating circumstances for each offense, the Board may require probation with the condition that the licensee not serve as a sponsor.	refusal to certify an application for licensure.	refusal to certify an application for licensure.	certify an application for licensure.		

(5) When the Board finds an applicant or licensee whom it regulates under Chapter 484, F.S., or a telehealth provider registered under section 456.47(4), F.S., has violated Section 456.063(3), 456.065(2) or 484.013(1)(b) or 456.072, F.S., by violating any of the following provisions, it shall issue a final order imposing appropriate penalties within the ranges recommended in the following disciplinary guidelines:

VIOLATIONS	RECOMMENDED PENALTIES			TELEHEALTH DISCIPLINE	
	First Offense	Second Offense	Third and subsequent Offenses	First Offense	Second Offense
(a) Failure to report allegations of sexual misconduct to the department, regardless of the practice setting in which the alleged sexual misconduct occurred. (Section 456.063(3), F.S.)	~~(a) From~~ R~~r~~eprimand to suspension of the license, and an administrative fine ranging from $1,500.00 to $5,000.00, or refusal to certify an application for licensure. If fraud or making a false or fraudulent representation is proven, the administrative fine is $10,000.00.	~~(a) From~~ P~~p~~robation to suspension of the license, and an administrative fine ranging from $5,000.00 to $7,500.00, or refusal to certify an application for licensure. If fraud or making a false or fraudulent representation is proven, the administrative fine is $10,000.00.	~~(a) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $7,500.00 to $10,000.00, or refusal to certify an application for licensure. If fraud or making a false or fraudulent representation is proven, the administrative fine is $10,000.00.	Reprimand to suspension	Suspension and a corrective action plan to revocation
(b) Failure to have a licensed optician on the business premises at any time that opticianry is being practiced. Should the violator be an unlicensed person, the Department	~~(b) From a~~ R~~r~~eprimand to probation of the license, and an administrative fine ranging from $250.00 to $750.00, or refusal to	~~(b) From~~ P~~p~~robation to suspension of the license, and an administrative fine ranging from $500.00 to $1,000.00, or refusal to	~~(b) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $750.00 to $1,000.00, or refusal to certify an	Reprimand to suspension	Suspension and a corrective action plan to revocation

will enter a cease and desist order. (Sections 456.065(2) and 484.013(1)(b), F.S.)	certify an application for licensure.	certify an application for licensure.	application for licensure.		
(c) Making misleading, deceptive, or fraudulent representations in or related to the practice of opticianry. (Section 456.072(1)(a), F.S.)	~~(c) From~~ R~~r~~eprimand to suspension of the license, and an administrative fine ranging from $1,000.00 to $5,000.00, and if fraudulent representations are proven, an administrative fine of $10,000.00, or refusal to certify an application for licensure.	~~(c) From~~ P~~p~~robation to revocation of the license, and an administrative fine ranging from $3,000.00 to $5,000.00, and if fraudulent representations are proven, an administrative fine of $10,000.00, or refusal to certify an application for licensure.	~~(c) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $5,000.00 to $10,000.00, and if fraudulent representations are proven, an administrative fine of $10,000.00, or refusal to certify an application for licensure.	Reprimand to suspension	Suspension and a corrective action plan to revocation
(d) Failing to comply with the educational course requirements for human immunodeficiency virus and acquired immune deficiency syndrome. (Section 456.072(1)(e), F.S.)	~~(d) From~~ L~~l~~etter of concern to reprimand of the license, and an administrative fine ranging from $500.00 to $1,000.00, or refusal to certify an application for licensure.	~~(d) From~~ R~~r~~eprimand to probation of the license, and an administrative fine ranging from $1,000.00 to $5,000.00, or refusal to certify an application for licensure.	~~(d) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $5,000.00 to $10,000.00, or refusal to certify an application for licensure.	Letter of Concern to reprimand	Reprimand to revocation
(e) Having been found liable in a civil proceeding for knowingly filing a false report or complaint with the department against another licensee.	~~(e) From~~ R~~r~~eprimand to suspension of the license, and an administrative fine ranging from $1,000.00 to $2,500.00, or	~~(e) From~~ P~~p~~robation to revocation of the license, and an administrative fine ranging from $2,500.00 to $5,000.00, or	~~(e) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $5,000.00 to $10,000.00, or refusal to	Reprimand to suspension	Suspension and a corrective action plan to revocation

(Section 456.072(1)(g), F.S.)	refusal to certify an application for licensure.	refusal to certify an application for licensure.	certify an application for licensure.		
(f) Aiding, assisting, procuring, employing, or advising any unlicensed person or entity to practice opticianry contrary to Chapters 484 and 456, F.S., or the rules of the department or the board. (Section 456.072(1)(j), F.S.)	~~(f) From~~ R~~r~~eprimand to suspension of the license, and an administrative fine ranging from $2,000.00 to $5,000.00, or refusal to certify an application for licensure.	~~(f) From~~ P~~p~~robation to revocation of the license, and an administrative fine ranging from $5,000.00 to $7,500.00, or refusal to certify an application for licensure.	~~(f) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $5,000.00 to $10,000.00, or refusal to certify an application for licensure.	Reprimand to suspension	Suspension and a corrective action plan to revocation
(g) Failure to perform legal obligation. (Section 456.072(1)(k), F.S.)	~~(g) From~~ R~~r~~eprimand to suspension of the license, and an administrative fine ranging from $500.00 to $2,500.00, or refusal to certify an application for licensure. If the violation is for fraud or making a false or fraudulent representation, the administrative fine is $10,000.00.	~~(g) From~~ P~~p~~robation to revocation of the license, and an administrative fine ranging from $2,500.00 to $5,000.00, or refusal to certify an application for licensure. If the violation is for fraud or making a false or fraudulent representation, the administrative fine is $10,000.00.	~~(g) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $5,000.00 to $10,000.00, or refusal to certify an application for licensure. If the violation is for fraud or making a false or fraudulent representation, the administrative fine is $10,000.00.	Reprimand to suspension	Suspension and a corrective action plan to revocation
(h) Making deceptive, untrue, or fraudulent representations in or related to the practice of a	~~(h) From~~ R~~r~~eprimand to suspension of the license, and an administrative	~~(h) From~~ P~~p~~robation to suspension of the license, without the ability to	~~(h) From~~ S~~s~~uspension to revocation of license, without the ability to	Reprimand to suspension	Suspension and a corrective action plan to revocation

profession or employing a trick or scheme in or related to the practice of a profession. (Section 456.072(1)(m), F.S.)	fine ranging from $1,000.00 to $5,000.00, and if fraudulent representation(s) is proven, an administrative fine of $10,000.00, or refusal to certify an application for licensure.	reapply, and an administrative fine ranging from $3,000.00 to $5,000.00, and if fraudulent representation(s) is proven, an administrative fine of $10,000.00, or refusal to certify an application for licensure.	reapply, and an administrative fine ranging from $5,000.00 to $10,000.00, and if fraudulent representation(s) is proven, an administrative fine of $10,000.00, or refusal to certify an application for licensure.		
(i) Practicing or offering to practice beyond the scope permitted by law or accepting and performing professional responsibilities the licensee knows, or has reason to know, the licensee is not competent to perform. (Section 456.072(1)(o), F.S.)	~~(i) From~~ R~~r~~eprimand to suspension of the license, and an administrative fine ranging from $1,000.00 to $2,500.00, or refusal to certify an application for licensure.	~~(i) From~~ P~~p~~robation to revocation of the license, and an administrative fine ranging from $2,500.00 to $5,000.00, or refusal to certify an application for licensure.	~~(i) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $5,000.00 to $10,000.00, or refusal to certify an application for licensure.	Reprimand to suspension	Suspension and a corrective action plan to revocation
(j) Delegating or contracting for the performance of professional responsibilities by a person when the licensee delegating or contracting for performance of such responsibilities knows, or has reason to know, such person is not	~~(j) From~~ R~~r~~eprimand to suspension of the license, and an administrative fine ranging from $1,000.00 to $2,500.00, or refusal to certify an application for licensure.	~~(j) From~~ P~~p~~robation to revocation of the license, and an administrative fine ranging from $2,500.00 to $5,000.00, or refusal to certify an application for licensure.	~~(j) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $5,000.00 to $10,000.00, or refusal to certify an application for licensure.	Reprimand to suspension	Suspension and a corrective action plan to revocation

qualified by training, experience, and authorization when required to perform them. (Section 456.072(1)(p), F.S.)					
(k) Improperly interfering with an investigation or inspection authorized by statute, or with any disciplinary proceeding. (Section 456.072(1)(r), F.S.)	~~(k) From~~ R~~r~~eprimand to probation of the license, and an administrative fine ranging from $500.00 to $1,000.00, or refusal to certify an application for licensure.	~~(k) From~~ P~~p~~robation to suspension of the license, and an administrative fine ranging from $1,000.00 to $5,000.00, or refusal to certify an application for licensure.	~~(k) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $5,000.00 to $10,000.00, or refusal to certify an application for licensure.	Reprimand to suspension and a corrective action plan	Suspension and a corrective action plan to revocation
(l) Engaging or attempting to engage a patient or client in verbal or physical sexual activity. For the purposes of this section, a patient or client shall be presumed to be incapable of giving free, full, and informed consent to verbal or physical sexual activity. (Section 456.072(1)(v), F.S.)	~~(l) From~~ R~~r~~eprimand to suspension of the license, and an administrative fine ranging from $1,000.00 to $5,000.00, or refusal to certify an application for licensure.	~~(l) From~~ P~~p~~robation to revocation of the license, and an administrative fine ranging from $5,000.00 to $7,500.00, or refusal to certify an application for licensure.	~~(l) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $5,000.00 to $10,000.00, or refusal to certify an application for licensure.	Reprimand to suspension	Suspension and a corrective action plan to revocation
(m) Failing to report to the board, or the department if there is no board, in writing within 30 days after the licensee has been convicted or found guilty of, or	~~(m) From~~ R~~r~~eprimand to suspension of the license, and an administrative fine ranging from $1,000.00 to $5,000.00, or	~~(m) From~~ P~~p~~robation to revocation of the license, and an administrative fine ranging from $5,000.00 to $7,500.00, or	~~(m) From~~ S~~s~~uspension to revocation of license, and an administrative fine ranging from $7,500.00 to $10,000.00, or refusal to	Reprimand to suspension	Suspension and a corrective action plan to revocation

entered a plea of nolo contendere to, regardless of adjudication, a crime in any jurisdiction. (Section 456.072(1)(x), F.S.)	refusal to certify an application for licensure.	refusal to certify an application for licensure.	certify an application for licensure.		
(n) Termination from a treatment program for impaired practitioners, which is overseen by an impaired practitioner consultant as described in Section 456.076, F.S. Termination can be for failure to comply with the terms of the monitoring or treatment contract entered into by the licensed practitioner, failure to successfully complete any drug treatment or alchohol-treatment program, or termination from a monitoring or treatment contract without good cause. (Section 456.072(1)(hh), F.S.)	~~(n) From~~ R~~r~~eprimand to suspension of the license, and an administrative fine ranging from $250.00 to $500.00, or refusal to certify an application for licensure.	~~(n) From~~ P~~p~~robation to revocation of the license, and an administrative fine ranging from $500.00 to $750.00, or refusal to certify an application for licensure.	~~(n) From~~ S~~s~~uspension to revocation of the license, and an administrative fine ranging from $750.00 to $1,000.00 or refusal to certify an application for licensure.	Reprimand to suspension	Suspension and a corrective action plan to revocation
(o) Being convicted of, or entering a plea of guilty or nolo contendere to, any misdemeanor or	~~(o)~~ Revocation and a fine of $10,000, or in the case of application for			Revocation	

felony, regardless of adjudication, under 18 USC s. 669, ss. 285-287, s. 371, s. 1001, s. 1035, s. 1341, s. 1343, s. 1347, s. 1349, or s. 1518, or 42 USC ss. 1320a-7b, relating to the Medicaid program. (Section 456.072(1)(ii), F.S.)	licensure, denial of license.				
(p) Failing to remit the sum owed to the state for overpayment from the Medicaid program pursuant to a final order, judgment, or settlement. (Section 456.072(1)(jj), F.S.)	~~(p) From a L~~letter of concern to probation of the license, and an administrative fine of $500.00 to $1000.00.	~~(p) From a R~~reprimand to suspension of license, and an administrative fine of $1000.00 to $5,000.00.	~~(p) From S~~suspension to revocation of license, and an administrative fine of $5,000.00 to $10,000.00.	Letter of concern to suspension and a corrective action plan	Reprimand to revocation
(q) Being terminated from the state Medicaid program, or any other state Medicaid program, or the federal Medicare program. (Section 456.072(1)(kk), F.S.)	~~(q) From a L~~letter of concern to probation of the license, and an administrative fine of $500.00 to $1000.00.	~~(q) From a R~~reprimand to suspension of license, and an administrative fine of $1,000.00 to $5,000.00.	~~(q) From S~~suspension to revocation of license, and an administrative fine of $1,000.00 to $5,000.00.	Letter of concern to suspension and a corrective action plan	Reprimand to revocation
(r) Being convicted of, or entering into a plea of guilty or nolo contendere to, any misdemeanor or felony, regardless of adjudication, which relates to health care fraud. (Section 456.072(1)(ll),	~~(r)~~ Revocation and a fine of $10,000, or in the case of application for licensure, denial of license.			Revocation	

F.S.)					

(6) - (7) No change.

Rulemaking Authority 456.079, 456.47(7), 484.005 FS. Law Implemented 456.072, 456.079, 465.47(4), 484.014 FS. History–New 3-5-87, Amended 3-30-89, 4-22-90, 12-23-90, 1-27-93, Formerly 21P-8.020, Amended 5-2-94, Formerly 61G13-8.020, 59U-8.020, Amended 12-3-01, 3-16-04, 5-25-06, 6-24-08, 4-8-10, 3-26-18,_____.

64B12-8.024 Out-of-State Telehealth Discipline

(1) The following disciplinary guidelines shall be followed by the board in imposing disciplinary penalties upon out-of-state telehealth providers registered pursuant to section 456.47(4), F.S., for violation of the below mentioned statutes and rules. For the purposes of this rule, the descriptions of the violations are abbreviated, and the full statute or rule cited should be consulted to determine the prohibited conduct.

VIOLATION	PENALTY RANGE	
	FIRST VIOLATION	SECOND AND SUBSEQUENT VIOLATIONS
a.~~1.~~ Fails to notify the ~~applicable~~ board~~, or the department if there is no board,~~ of any adverse actions taken against his or her license. (Section 456.47(4)(i), F.S.);	Letter of Concern to suspension and a corrective action plan	Suspension and a corrective action plan to revocation
b.~~2.~~ Has restrictions placed on or disciplinary action taken against his or her license in any state or jurisdiction. (Section 456.47(4)(i), F.S.)	Letter of concern to revocation as closely as possible to same penalty as imposed in other jurisdiction	Letter of concern to revocation as closely as possible to same penalty as imposed in other jurisdiction to revocation
c.~~3.~~ Violates any of the requirements of section 456.47, F.S. (Section 456.47(4)(i), F.S.)	Letter of Concern to suspension and a corrective action plan	Suspension and a corrective action plan to revocation
d.~~4.~~ Commits any act that constitutes grounds for disciplinary action under s. 456.072(1), or s. 484.014 ~~465.016(1)~~, F.S.	As stated in rule 64B12-8.020, F.A.C.	As stated in rule 64B12-8.020, F.A.C.

(2) The range of disciplinary action for registered out-of-state telehealth providers shall be, in ascending order of severity:~~,~~ letter of concern, reprimand, suspension, and revocation.

(3) A suspension may be for a definiate term or may be accompanied by a corrective action plan established by the Board, as stated in rule 64B12-8.020, F.A.C.

(4) A suspension for a definate term may be terminated early only upon approval of the Board. A suspension accompnaied by a corrective action plan may be lifted upon successful successful complaince with the corrective action or otherwise determined by the Board.

(5) A "corrective action plan" must accompany a suspension and includes rehabilitative provisions established by the Board which are narrowly tailored to address the conduct which resulted in the underlying disciplinary violations. In order to satisfy a corrective action plan, the Registrant must provide proof of successful completion of all provisions to the Board. A corrective action plan may follow a suspension for a definite term and require continued suspension until successful compliance with the corrective action plan. Nothing in this paragraph shall be interpreted as restricting the Board's ability to impose a suspension for a definite term absent or accompanied by a corrective action plan.

Rulemaking Authority 456.47(4), 456.47(7) FS. Law Implemented 456.47(4) FS. History–New _____.

NAME OF PERSON ORIGINATING PROPOSED RULE: Board of Opticianry

NAME OF AGENCY HEAD WHO APPROVED THE PROPOSED RULE: Board of Opticianry

DATE PROPOSED RULE APPROVED BY AGENCY HEAD: April 24, 2020

DATE NOTICE OF PROPOSED RULE DEVELOPMENT PUBLISHED IN FAR: XXXXXXXXX

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY

JANE DOE PLAINTIFF

v. CIVIL ACTION NO. 3:19-CV-236-JRW

SUPREME COURT OF KENTUCKY, et al. DEFENDANTS

ORDER

1. The Court **GRANTS** Jane Doe's motion for leave to amend (DN 14).

2. The Court **DIRECTS** the Clerk to file Doe's Amended Complaint (DN 14-1).

3. The Court **GRANTS** the motions to dismiss (DNs 16, 18, & 19).

4. The Court **DENIES AS MOOT**:

   a. The first motions to dismiss (DNs 7, 8, 10);

   b. Doe's motion for an extension of time (DN 13);

   c. Doe's motion to proceed under a pseudonym (DN 33); and

   d. The Board Defendants' motion for leave to file an Amended Response in Opposition to Doe's motion for leave to proceed under a pseudonym (DN 37).

5. The Court **DISMISSES** Counts I, II, & III of the Amended Complaint, with prejudice.

6. The Court **DISMISSES** Counts IV & V of the Amended Complaint, without prejudice.

MEMORANDUM OPINION

Courts, journalists, and scholars have extensively documented the mental health issues that afflict lawyers.[1] The problems begin in law school, where "law students have disproportionate levels of stress, anxiety, and mental health concerns compared with other populations."[2] After graduation, lawyers suffer from depression at higher rates than non-lawyers.[3] Not long ago, the Kentucky Bar Association President described a spike in Kentucky lawyers dying by suicide as "disproportionate" and "disconcerting."[4]

Jane Doe was a lawyer in Florida. She moved to Kentucky. She wanted to practice law here. Bureaucrats didn't want her to. They thought her mental disability made her unfit. For over two years, they stopped her. But she didn't give up. And they eventually relented.

Then Doe sued them, alleging they had illegally asked about her mental health history and treatment, illegally forced her to turn over her medical records and her therapists' notes from their counseling sessions, and illegally treated her like a criminal because of her disability.

This case is not only about Jane Doe. It's also about the lawyers who decide who else can be a lawyer.

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[1] *See, e.g.*, *ACLU of Indiana v. Individual Members of the Indiana State Board of Law Examiners*, No. 1:09-cv-842-TWP-MJD, 2011 WL 4387470, at *1 (S.D. In. 2011); ROSA FLORES & ROSE MARIE ARCE, *Why Are Lawyers Killing Themselves?*, CNN.COM, Jan. 24, 2014, https://www.cnn.com/2014/01/19/us/lawyer-suicides/index.html;
PATRICK R. KRILL, RYAN JOHNSON, AND LINDA ALBERT, *The Prevalence of Substance Use and Other Mental Health Concerns Among American Attorneys*, 10 JOURNAL OF ADDICTION MEDICINE 46, 52 (Jan. 2016).

[2] JEROME M. ORGAN, DAVID B. JAFFE, & KATHERINE M. BENDER, *Suffering in Silence: The Survey of Law Student Well-Being and the Reluctance of Law Students to Seek Help for Substance Use and Mental Health Concerns*, 66 JOURNAL OF LEGAL EDUCATION 116, 121 (Autumn 2016).

[3] FLORES & ARCE, *Why Are Lawyers Killing Themselves?*.

[4] *Lawyer Suicides Concern Colleagues*, THE COURIER-JOURNAL, Jun. 3, 2013, https://www.usatoday.com/story/news/nation/2013/06/03/lawyer-suicides-concern-colleagues/2383627/.

Under the Kentucky Constitution, that power belongs to the Supreme Court of Kentucky.[5] The court, in turn, delegates that job to its Bar Bureaucracy:

- The Character and Fitness Committee and Board of Bar Examiners comprise the Office of Bar Admissions.[6]
- The Character and Fitness Committee prohibits people from practicing law if the committee thinks they are immoral[7] or unfit.[8]
- The Board of Bar Examiners prohibits people from practicing law if they can't pass a timed exam that tests their ability to memorize whole areas of the law they will never again need to know anything about.[9]
- The Kentucky Bar Association decides who gets to stay a lawyer.[10]
- The Kentucky Lawyer Assistance Program keeps tabs on lawyers and aspiring lawyers who have mental health issues by monitoring their medications, counseling, where they live, and where they travel.[11]

Anyone with any power in this Bar Bureaucracy is a lawyer. So, just like an oil or drug cartel, those who are already selling something get to decide who else may sell that same thing. Of course, unlike most cartels, this one is legal. In fact, the Kentucky Constitution requires it.[12]

If Doe had sued the Bar Bureaucracy back when it stopped her from entering the market, she would have had standing to ask the Court to block it from treating her like it did. But you can't blame Doe for waiting to sue. If your goal is to persuade the Bar Bureaucracy's lawyers to let you

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[5] Ky. Const. § 116 ("The Supreme Court shall, by rule, govern admission to the bar and discipline members of the bar.").
[6] SCR 2.000. Some of the Supreme Court Rules cited here have been recently amended due to the ongoing pandemic, but none of the recent amendments are material to this analysis.
[7] SCR 2.011(1); SCR 2.040(3).
[8] SCR 2.011(2); SCR 2.040(3).
[9] SCR 2.020(3); SCR 2.080.
[10] SCR 3.025; SCR 3.050; SCR 3.060; SCR 3.640(8)(d); SCR 3.645(4); *see, e.g.*, *Grinnell v. Kentucky Bar Association*, 602 S.W.3d 784 (Ky. 2020); *see also* SCR 3.035(1)(c) ("Failure to maintain a current address which allows for physical service of process with the Director [of the Kentucky Bar Association] may be prosecuted in the same manner as a violation of the Rules of Professional Conduct.").
[11] SCR 3.900; SCR 3.910(2); DN 14-1 ¶¶ 40, 72.
[12] Ky. Const. § 116.

join their club, it isn't a good strategy to poke them in the eye with a lawsuit that accuses them of violating the Americans with Disabilities Act and the United States Constitution.

Because the Bar Bureaucracy (finally) allowed Doe to practice law, she lacks standing for prospective relief. And because legislative and judicial immunity protect Bar Bureaucracies from money damages arising from the promulgation of bar rules and the adjudication of bar applications, the Court will dismiss Doe's federal claims. In addition, the Court declines to exercise supplemental jurisdiction over Doe's state-law claims.

The Bar Bureaucracy won this round against an applicant it deemed suspect and undesirable. But there will be more applicants — and more lawsuits. Some of those plaintiffs will have standing to seek prospective relief. And when they do, the Bar Bureaucracy will have to answer for a medieval approach to mental health that is as cruel as it is counterproductive.

I.

A.

Several federal and state courts have held that the Americans with Disabilities Act prohibits Bar Bureaucracies from unnecessarily interrogating applicants about their mental health.[13] So too did the Department of Justice. In 2014, it concluded that questions about applicants' mental health

[13] *In re Application of Underwood & Plano*, BAR-93-21, 1993 WL 649283, at *1 (Me. Dec. 7, 1993); *Ellen S. v. Florida Bd. Of Bar Examiners*, 859 F. Supp. 1489 (S.D. Fla. 1994); *Clark v. Virginia Bd. Of Bar Examiners*, 880 F. Supp. 430 (E.D. Va. 1995); *ACLU of Indiana v. Individual Members of the Indiana State Bd. of Law Examiners*, No. 1:09-cv-842-TWP-MJD, 2011 WL 4387470, at *6 (S.D. Ind. Sept. 20, 2011); *see also Medical Society of New Jersey v. Jacobs*, No. 93-3670 (WGB), 1993 WL 413016, at *8 (D. N.J. Oct. 5, 1993); *In Re Petition of Frickey*, 515 N.W.2d 741 (Minn. 1994); *Doe v. Judicial Nominating Commission*, 906 F. Supp. 1534, 1542-43 (S.D. Fla. 1995); *In re Petition & Questionnaire for Admission to Rhode Island Bar*, 683 A.2d 1333, 1337 (R.I. 1996); *Brewer v. Wisconsin Bd. of Bar Examiners*, No. 04-C-0694, 2006 WL 3469598, at *8 (E.D. Wis. Nov. 28, 2006), *aff'd*, 270 F. App'x 418 (7th Cir. 2008); *but see Applicants v. Texas State Bd. of Law Examiners*, No. A 93 CA 740 SS, 1994 WL 923404, at *9 (W.D. Tex. Oct. 11, 1994); *McCready v. Illinois Bd. of Admissions to Bar*, No. 94 C 3582, 1995 WL 29609, at *1 (N.D. Ill. Jan. 24, 1995); *In re Henry*, 841 N.W.2d 471, 476 n.5 (S.D. 2013); *see generally* LANNY KING, Note, *The Kentucky Board of Bar Examiners' Character and Fitness Certification Questionnaire: Are Mental Health Inquiries a Violation of the Americans with Disabilities Act?*, 84 KY. L.J. 685 (1996).

do "*not* provide an accurate basis for predicting future misconduct."[14] Instead, they likely "deter applicants from seeking counseling and treatment for mental health concerns, which fails to serve the Court's interest in ensuring the fitness of licensed attorneys."[15] In other words, according to the Department of Justice, a Bar Bureaucracy's decision to ask applicants about their mental health status makes aspiring lawyers *less* fit to practice law.[16]

B.

Jane Doe was born and raised in Kentucky.[17] She earned her Florida law license in 2006 and worked there in government and private practice. After a 2014 diagnosis for Bipolar I Disorder, Doe entered a monitoring program run by the Florida Lawyers' Assistance Program. She was, and remains, in good standing with the Florida bar.[18]

In December 2015, Doe applied for a Kentucky law license. The application required her to disclose her history of depression and Bipolar I Disorder and that she had undergone treatment. And so began her 994-day tale of bureaucratic woe.

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[14] Letter from U.S. Department of Justice, Civil Rights Division, to Karen L. Richards, Executive Director, Vermont Human Rights Commission (Jan. 21, 2014) at 5 (emphasis added).

[15] Letter from U.S. Department of Justice, Civil Rights Division, to the Honorable Bernette J. Johnson, Chief Justice, Louisiana Supreme Court, Elizabeth S. Schell, Executive Director, Louisiana Supreme Court Committee on Bar Admissions, Charles B. Plattsmier, Chief Disciplinary Counsel, Louisiana Attorney Disciplinary Board (Feb. 5, 2014) at 23.

[16] To be clear, neither Doe nor the Department of Justice has argued that Bar Bureaucracies cannot ask about an applicant's relevant past *conduct*, regardless of whether mental disability had a role in that conduct. Rather, they argue that Bar Bureaucracies cannot ask about an applicant's status as a person with a mental disability, and they cannot treat an applicant differently based on that status. So, for example, it's fair game to ask, "Have you ever been fired?" Or, "Have you ever robbed a bank?" Applicants' mental health provides no escape from the questions, even if they had a mental disability when they were fired (or robbed the bank).

[17] The Court takes the facts from the Amended Complaint and draws all reasonable inferences in Doe's favor. *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). The Court also relies on the Supreme Court Rules, which are public record. *Bassett v. National Collegiate Athletic Association*, 528 F.3d 426, 430 (6th Cir. 2008).

[18] DN 14-1 ¶ 18.

Doe disclosed everything Kentucky's Bar Bureaucracy required her to disclose. That included two required releases giving the Bar Bureaucracy "complete access to her personal and private medical records, including treatment notes"[19] and a third for her monitoring records from Florida. In January 2016, Doe's doctor told the Bar Bureaucracy that Doe had "compli[ed] with medical advice, prescription instructions," and what the Florida bar required of her.[20] Doe's doctors have always said she should "continue practicing law without concerns for her or the public's safety."[21]

The Bar Bureaucracy pressed on. So Doe sent in yet another form. This fourth medical records release granted "access to inpatient records, outpatient records, and treatment notes."[22]

The next month, shortly before Doe took the February 2016 bar exam, the Character and Fitness Committee refused to approve her application. Instead, in March, the Bar Bureaucracy proposed, and Doe signed, a "consent agreement" for conditional admission.[23] It required 1) a Kentucky Contract (more on that later); 2) compliance with Florida's rules and Kentucky's rules and reporting requirements; and 3) "residency in Kentucky . . . unless" Doe was relocating for work and the Bar Bureaucracy approved.[24]

The consent agreement did not provide details about the Kentucky Contract. Yvette Hourigan, Director of the Kentucky Lawyer Assistance Program, said the contract would mirror the monitoring arrangement Doe had with the Florida Lawyers' Assistance Program, which was tailored to Doe's diagnosis.

Doe passed the bar exam. She paid the dues and swearing-in fee.

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[19] *Id.* ¶ 27.
[20] *Id.* ¶ 34.
[21] *Id.* ¶ 21.
[22] *Id.* ¶ 36.
[23] *Id.* ¶¶ 40, 41.
[24] *Id.* ¶ 40.

C.

Although Hourigan had promised to send a proposed contract, she didn't. Instead, she arranged to meet with Doe the morning of the new lawyers' swearing-in ceremony at the State Capitol. That day, Hourigan "texted that she was running late and they would meet on the steps of the Capitol" minutes before the swearing-in.[25]

At this point, you might be thinking that a public place with many of Doe's peers isn't an ideal place to discuss private medical issues. (It isn't.)

You might also wonder if other bar applicants could overhear their discussion.[26] (They could.)

Instead of the personalized contract Hourigan had promised, she presented a boilerplate contract. It included a host of medically unnecessary requirements, including random drug and alcohol testing. When Doe told Hourigan she had never had drug or alcohol problems, Hourigan told her the provisions were standard. Hourigan, who is not a doctor[27] but plays one on the Capitol steps, also said Doe's medications required abstinence from alcohol. (They don't.)

Doe refused to sign the contract. She told Hourigan it violated the Americans with Disabilities Act, and "the ADA does not permit the disabled to be treated like criminals."[28] (It doesn't.)

D.

Later in 2016, after Doe provided yet another medical-records release, Doe's doctor advised Hourigan that Doe could drink alcohol on her medication.

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[25] *Id.* ¶ 49.
[26] *Id.* ¶¶ 50, 54.
[27] SCR 3.910(2).
[28] DN 14-1 ¶ 52.

Hourigan partially relented. She removed the alcohol provisions from the Kentucky Contract. But other intrusive and unnecessary requirements remained. For example, Doe had to tell Hourigan if she was leaving town for longer than a week.

Unable to practice law, Doe taught civics, safety, and sewing to refugees. Meanwhile, the Bar Bureaucracy ordered her to appear for a formal hearing, at Doe's expense, to show cause for allegedly violating the consent agreement. The Bar Bureaucracy's lawyer, Elizabeth Feamster, demanded even more documents, as well as the contact information for Doe's employer.

Doe asked Feamster if they could "discuss the ADA issues and how the parties could resolve concerns on both sides," rather than having a hearing.[29] But Feamster demanded that Doe prove she wasn't practicing law. In December 2016, Doe received in-patient treatment for her disability.

Doe's formal hearing was on April 27, 2017. She again expressed her concerns about violations of the Americans with Disabilities Act. Feamster relied solely on Doe's disability in denying Doe a full law license. Soon after, the Character and Fitness Committee recommended that the Supreme Court of Kentucky permanently revoke Doe's conditional license. Recall that on the record before us, Doe had been licensed by Florida for the past eleven years — and had practiced there for the first nine of those years — and remained in good standing that whole time.[30]

E.

A year later, in 2018, Doe successfully completed Florida's monitoring program. Her doctor wrote yet another letter to the Bar Bureaucracy saying he still "had no concerns regarding her mental health and encouraged her to continue practicing law."[31]

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[29] *Id.* ¶ 76.
[30] *Id.* ¶ 18.
[31] *Id.* ¶ 92.

In July 2018, the Bar Bureaucracy held another hearing. Again, they interrogated Doe about her disability. After the hearing, Feamster demanded still more information about Doe's medical treatment. And yet again, Doe told the Bar Bureaucracy that they were violating the Americans with Disabilities Act.

Finally, in August 2018, Doe was unconditionally admitted to practice law in Kentucky.

Her bar file still contains protected health information and show cause orders suggesting that "her disability and treatment [are] character and professional flaws."[32]

In 2019, Doe filed this suit against the Bar Bureaucracy for violating the Americans with Disabilities Act, the Rehabilitation Act, and the Equal Protection Clause.[33] She also sued under Kentucky law for defamation and intentional infliction of emotional distress.[34]

F.

The Bar Bureaucracy moves to dismiss for lack of subject-matter jurisdiction and for failure to state a claim.[35] In addition, some defendants object to Doe's use of a pseudonym.[36]

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[32] *Id.* ¶ 98.

[33] Doe brings her ADA and Rehabilitation Act claims against the institutional defendants (Supreme Court of Kentucky; Office of Bar Admissions; Character and Fitness Committee; Board of Bar Examiners; Kentucky Bar Association; and Kentucky Lawyer Assistance Program entities). *See id.* ¶¶ 108-13. She brings her constitutional claim against "All Defendants." *See id.* ¶¶ 114-24. This constitutional claim concerns the defendants' "system." *See id.* ¶ 118 ("licensing and bar admission system"), ¶ 119 ("licensing and bar admission system"), ¶ 120 ("licensing and bar admission system"), ¶ 121 ("licensing and bar admission system"), ¶ 122 ("licensing and bar admission system"), ¶ 124 ("licensing and bar admission system"). Therefore, this count is best construed to raise claims against the institutional defendants, as well as Hourigan in her official capacity. As for Feamster, earlier in the Amended Complaint, Doe is explicit that Feamster is sued only in her individual capacity. *Compare id.* ¶ 10, *with id.* ¶ 13. It's true this claim also says, "Defendants' discriminatory actions against Plaintiff based on her status as an individual with a mental disability were intentional or committed with reckless or callous disregard for her rights." *Id.* ¶ 123. But that paragraph can best be construed to concern the defendants' conduct in their official capacities. That's because the "actions against Plaintiff based on her status" were, by the very terms of Doe's Amended Complaint, in accord with the "discriminatory licensing and bar admission system." *Id.* ¶ 124. With regard to Doe's federal claims, Feamster did not, in her individual capacity, do anything to injure Doe.

[34] Doe's state-law claims concern the conduct of Feamster and Hourigan in their individual capacities.

[35] DNs 16, 18, & 19; *see also* DNs 7, 8, & 10.

[36] DN 8 at #179; DN 10-1 at #250; DN 18 at #366; DN 19 at #383. Doe later moved for leave to proceed under a pseudonym. DN 33. Some of the defendants opposed Doe's motion. DNs 34 & 35.

As for the pseudonym, Kentucky law explicitly protects the confidentiality of those who receive help (or hindrance) from the Kentucky Lawyer Assistance Program.[37] Kentucky law also protects Doe's character and fitness results from public disclosure.[38] And Doe's prior conditional admission status is confidential.[39]

The Bar Bureaucracy knows who Doe is. Opposing her pseudonym does little for its credibility. But ultimately that motion is moot because Doe's suit will be dismissed.[40]

II.

A.

Article III of the Constitution limits the Court's jurisdiction to only "Cases" and "Controversies."[41] Doe asks for injunctive relief, damages, and attorneys' fees.[42] She must have standing for each claim "and for each form of relief that is sought."[43]

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[37] SCR 3.990; *see also* KENTUCKY LAWYER ASSISTANCE PROGRAM, *KYLAP Staff,* https://www.kylap.org/about-kylap/kylap-staff/ ("All contact with KYLAP is confidential.").
[38] *See* SCR 2.008.
[39] SCR 2.042(4).
[40] Doe asks to amend her Complaint. DN 14. She voluntarily dismissed her claims against some defendants, none of whom have answered or moved for summary judgment. DN 14-1 at #267; Fed. R. Civ. P. 41(a)(1)(A)(i). Dismissing them without prejudice is appropriate. Fed. R. Civ. P. 41(a)(1)(B). The remaining defendants oppose the amendment on futility grounds and alternatively move to dismiss for lack of subject-matter jurisdiction and for failure to state a claim. DNs 16, 18, & 19.
[41] U.S. CONST. Art. III, § 2; *see Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 157 (2014).
[42] DN 14-1 at #290.
[43] *Town of Chester, New York v. Laroe Estates, Inc.*, 137 S.Ct. 1645, 1650 (2017) (quoting *Davis v. Federal Election Commission*, 554 U.S. 724, 734 (2008)) (cleaned up).

1.

For injunctive relief, Doe wants the Bar Bureaucracy "to remove show cause orders and medical information and records from [her] file."[44] But Doe has not alleged any harm that may result from the allegedly tainted file, much less that an injury is "certainly impending."[45]

Although it took years to get there, Doe is now a full-fledged Kentucky lawyer.[46] And if she avoids any disciplinary issues here in Kentucky — just as she remained in good standing in Florida — the file may never come into play.[47] It's conceivable that her file could be used at some point for some other purpose. But any future injury is "speculative or tenuous," so Doe has "no standing to seek injunctive relief."[48]

2.

Doe also lacks standing for the federal claims she brings against the Office of Bar Admissions, the Kentucky Board of Bar Examiners, the Kentucky Bar Association, the Kentucky Lawyer Assistance Program entities, and Yvette Hourigan in her official capacity. There is no "causal connection" between Doe's injuries and these defendants.[49] They didn't block her from practicing law, if only because they didn't have that power.

Dissecting this byzantine Bar Bureaucracy takes a little digging. It turns out that none of those entities have any authority in the character and fitness process. Instead, the Character and Fitness Committee makes its own rules, which the Supreme Court of Kentucky approves.[50]

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[44] DN 14-1 at #290. Specifically, as of December 2018, Doe's "official bar files contained confidential and protected health information and multiple orders to show cause which reference her disability and treatment as character and professional flaws." DN 14-1 ¶ 98.
[45] *Clapper v. Amnesty International USA*, 568 U.S. 398, 401 (2013) (quoting *Whitmore v. Arkansas*, 495 U.S. 149, 158 (1990)).
[46] DN 14-1 ¶ 97.
[47] *Id.* ¶ 18.
[48] *Grendell v. Ohio Supreme Court*, 252 F.3d 828, 833 (6th Cir. 2001).
[49] *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992).
[50] SCR 2.000.

Likewise, the Character and Fitness Committee decides who has the "character and fitness" to practice law, and only the Supreme Court of Kentucky can review that decision.[51] The same is true for deciding who is conditionally admitted: Only the Character and Fitness Committee makes that call,[52] and only the Supreme Court can overrule it.[53] Thus, although the Character and Fitness Committee is a division of the Office of Bar Admissions, the Office of Bar Admissions doesn't actually make any final decisions — at least not for our purposes.

3.

Doe does, however, have standing for her federal-law damages claims against the Supreme Court of Kentucky and the Character and Fitness Committee. They had the power to (and did) decide to ask her about her mental health.[54] They had the power to (and did) put her through the ringer based on her honest answers.[55] They had the power to (and did) deny her an unconditional license for over two years.[56] They had the power to (and did) impose administrative and financial burdens on her that they didn't impose on other applicants.[57]

All these injuries are "fairly traceable" to the Kentucky Supreme Court and the Character and Fitness Committee.[58] And a damages decision in Doe's favor would redress these injuries.[59]

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[51] SCR 2.011; SCR 2.060.
[52] SCR 2.042.
[53] SCR 2.060.
[54] *See* DN 14-1 ¶ 26. While Doe refers here to the "KBA," the Kentucky Bar Association does not determine an applicant's character and fitness to practice. *Compare* SCR 3.025 *with* SCR 2.060.
[55] *See, e.g.*, DN 14-1 ¶ 36 (requiring "inpatient records, outpatient records, and treatment notes").
[56] *See id.* ¶ 97.
[57] *Cf. id.* ¶ 78.
[58] *Lujan*, 504 U.S. at 560 (cleaned up).
[59] *Id.* at 561.

Doe also has standing to sue both Hourigan and Feamster personally for defamation and intentional infliction of emotional distress. The remaining claims and defendants are:

- The Supreme Court of Kentucky (federal-law claims);
- The Character and Fitness Committee (federal-law claims); and
- Hourigan and Feamster (state-law claims).

B.

The second jurisdictional question concerns the *Rooker-Feldman* doctrine. Some of the defendants rely on it in asking for dismissal.[60] But *Feldman* explicitly says the Court has "subject matter jurisdiction over general challenges to state bar rules, promulgated by state courts in nonjudicial proceedings, which do not require review of a final state court judgment in a particular case."[61] Here, Doe challenges Kentucky's bar rules, including its "licensing and bar admission system."[62] The *Rooker-Feldman* argument fails.[63]

C.

The third jurisdictional question is straight out of a Fed Courts exam. Is state sovereign immunity the type of jurisdictional issue the Court must decide before it considers non-jurisdictional issues (like judicial and legislative immunity)?

Let's start with the argument for "yes." The Sixth Circuit has said, repeatedly and as recently as last week, that state sovereign immunity is "jurisdictional."[64] Also, the Eleventh

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[60] DN 18 at #352-55; DN 19 at #383.
[61] *District of Columbia Court of Appeals v. Feldman*, 460 U.S. 462, 486 (1983).
[62] DN 14-1 ¶¶ 118-22, & 124.
[63] *See VanderKodde v. Mary Jane M. Elliott, P.C.*, 951 F.3d 397, 409 (6th Cir. 2020) (Sutton, J., concurring) ("Absent a claim seeking review of a final state court judgment, a federal court tempted to dismiss a case under *Rooker-Feldman* should do one thing: Stop.").
[64] *Russell v. Lundergan-Grimes*, 784 F.3d 1037, 1046 (6th Cir. 2015); *Doe v. DeWine*, 910 F.3d 842, 848 (6th Cir. 2018); *Ladd v. Marchbanks*, --- F.3d ---, 2020 WL 4882885, at *1 n.2 (6th Cir. Aug. 20, 2020).

Amendment talks about the "Judicial power of the United States" and where it "shall not be construed to extend," which sure sounds jurisdictional.[65]

But here's why, in this case, the answer is "no." Unlike subject-matter jurisdiction, which can never be waived, a state can waive its sovereign immunity.[66] In the same vein, while the party invoking jurisdiction has the burden of establishing jurisdiction, a defendant invoking sovereign immunity has the burden to show it applies.[67] That's because the Eleventh Amendment "enacts a sovereign immunity from suit, rather than a nonwaivable limit on the Federal Judiciary's subject-matter jurisdiction."[68] It "does not automatically destroy original jurisdiction."[69]

Under *Nair v. Oakland County Community Mental Health Authority*, "a State that has authority to waive the broader question (of whether it is amenable to suit at all) has authority to waive the narrower question (of whether a court must address a sovereign-immunity defense before the merits)."[70] And that's what happened here: Although the defendants raised sovereign immunity in their motions to dismiss, at oral argument, they expressly declined to raise it as a threshold defense, and they specifically cited *Nair* in doing so.[71] Thus, under *Nair*, the Court may address judicial and legislative immunity before state sovereign immunity.[72]

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[65] U.S. CONST. Amend. XI.
[66] *Wisconsin Department of Corrections v. Schacht*, 524 U.S. 381, 389 (1998).
[67] *Nair v. Oakland County Community Mental Health Authority*, 443 F.3d 469, 474 (6th Cir. 2006).
[68] *Idaho v. Coeur d'Alene Tribe of Idaho*, 521 U.S. 261, 267 (1997); *see also Nair*, 443 F.3d at 474 (The Eleventh Amendment "defense is not coextensive with the limitations on judicial power in Article III.") (quoting *Calderon v. Ashmus*, 523 U.S. 740, 745 n.2 (1998)) (cleaned up).
[69] *Schacht*, 524 U.S. at 389.
[70] 443 F.3d at 476 (citing *Alden v. Maine*, 527 U.S. 706, 737 (1999)).
[71] Oral Argument, Aug. 26, 2020 (Q: "[You are] declining to raise sovereign immunity as a threshold defense?" KBA: "Correct. We are not waiving sovereign immunity, but we are declining to raise it as a set — threshold defense as set forth in *Nair*."; Board Defendants: "Yes, sir. Same."; Supreme Court: "Correct . . . to reserve it in the event that the sovereign would otherwise lose on the merits.").
[72] *See, e.g.*, *Nair*, 443 F.3d at 477; *West v. Berkman*, No. 19-2384, 2020 U.S. App. LEXIS 25450, at *6-8 (6th Cir. Aug. 11, 2020); *Kitchen v. Noe*, Nos. 18-2254/19-1125, 2019 U.S. App. LEXIS 24499 at *4 (6th Cir. Aug. 15, 2019); *cf. Vermont Agency of Natural Resources v. United States ex rel. Stevens*, 529 U.S. 765, 779 (2000) ("We . . . have routinely addressed *before* the question whether the Eleventh Amendment

This conclusion doesn't contravene the precedents of this circuit that at most imply otherwise. Even *Russell v. Lundergan-Grimes*, which held that Eleventh Amendment immunity is "jurisdictional," said that courts are "not required" to raise Eleventh Amendment immunity if the defendant doesn't.[73] In contrast, the Court must always consider issues of subject-matter jurisdiction, even if the parties don't raise them.[74]

In this case, the sovereign immunity question is complex. Congress has abrogated sovereign immunity when a state violates the Americans with Disabilities Act and also the Fourteenth Amendment.[75] Courts have split on whether systems similar to Kentucky's violate the Americans with Disabilities Act. The issue "has been the subject of intense controversy."[76] And if the Bar Bureaucracy violated only the Americans with Disabilities Act and not the Fourteenth Amendment, then the Court would decide "whether Congress's purported abrogation of sovereign immunity as to that class of conduct is nevertheless valid."[77]

Those issues can and should be avoided by first answering the question of judicial and legislative immunity — a question on which there is binding precedent directly on point.

D.

In *Sparks v. Character & Fitness Committee of Kentucky*, the Bar Bureaucracy refused to admit Gerald Sparks to the bar.[78] He sued for damages.[79] The Sixth Circuit held that "the nature

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forbids a particular statutory cause of action to be asserted against States, the question whether the statute itself *permits* the cause of action it creates to be asserted against States.").

[73] *Russell*, 784 F.3d at 1046.

[74] *Fort Bend County, Texas v. Davis*, 139 S.Ct. 1843, 1849 (2019).

[75] *United States v. Georgia*, 546 U.S. 151, 159 (2006) ("Thus, insofar as Title II creates a private cause of action for damages against the States for conduct that *actually* violates the Fourteenth Amendment, Title II validly abrogates state sovereign immunity.").

[76] *Brewer v. Wisconsin Board of Bar Examiners*, No. 04-C-0694, 2006 WL 3469598, at *8 (E.D. Wi. 2006), *aff'd*, 270 F.App'x 418 (7th Cir. 2008).

[77] *Georgia*, 546 U.S. at 159.

[78] 859 F.2d 428 (6th Cir. 1988).

[79] *See id.* at 429.

of the function involved in determining qualifications for admission to the bar" is "a judicial act."[80] Therefore, "absolute immunity" shielded both the Supreme Court of Kentucky and the Character and Fitness Committee.[81]

The Sixth Circuit reached the same result in *Mayfield v. Francks*.[82] And again in *Thomas v. Michigan State Board of Law Examiners*.[83] And once again in *Lawrence v. Welch*.[84] In each instance, judicial immunity protected a Bar Bureaucracy when plaintiffs sought damages for how it adjudicated their bar applications.[85]

Another immunity, legislative immunity, protects the Supreme Court of Kentucky from a challenge to its promulgation of bar admission rules, including the rules requiring the Character and Fitness Committee to interrogate applicants about their mental health. In *Supreme Court of Virginia v. Consumers Union of the United States*, the U.S. Supreme Court held that the Bar Bureaucracy's "members are the State's legislators for the purpose of issuing the Bar Code," so they "are immune from suit when acting in their legislative capacity."[86] Likewise, the Sixth Circuit has applied legislative immunity to block suits challenging how a state supreme court and its delegates promulgated rules about who gets to become a lawyer.[87]

By this point, you might be wondering how a plaintiff could ever challenge the way a Bar Bureaucracy asks applicants about their mental health and puts them through the ringer if they

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[80] *Id.* at 433.
[81] *Id.* at 434.
[82] 959 F.2d 235 (6th Cir. 1992) (unpublished table decision).
[83] 41 F.3d 1508 (6th Cir. 1994) (unpublished table decision).
[84] 531 F.3d 364 (6th Cir. 2008).
[85] *See Lawrence*, 531 F.3d at 372-73 (affirming district court's dismissal of claim seeking damages for failure to state a claim); *Thomas*, 1994 WL 659148, at *2 ("The individual state defendants are absolutely immune from a civil rights action for damages."); *Mayfield*, 1992 WL 73151, at *1 ("The dismissal of Mayfield's monetary claims was also appropriate. Monetary relief is unavailable to Mayfield because the defendants were protected by absolute immunity for the actions that they performed at the behest of the Michigan Supreme Court.").
[86] 446 U.S. 719, 734 (1980).
[87] *See, e.g.*, *Abick v. Michigan*, 803 F.2d 874, 878 (6th Cir. 1986).

truthfully disclose a mental disability. The answer is that a plaintiff could sue for prospective relief — a declaration that the questions violate federal law and an injunction prohibiting the Bar Bureaucracy from asking them. To have standing, the plaintiff would need to be a bar applicant, not an unconditionally licensed lawyer like Doe was when she filed this suit.

E.

Let's recap. For her federal-law claims, Doe lacks standing for prospective relief. She also lacks standing to sue the institutional defendants other than the Supreme Court of Kentucky and the Character and Fitness Committee because the others didn't cause her injuries. Judicial immunity and legislative immunity shield the Supreme Court of Kentucky and Character and Fitness Committee from damages.

Doe's federal claims must therefore be dismissed.[88] And the Court declines to exercise jurisdiction over her state-law claims.[89]

* * *

Law school is hard. The stress, rigor, and competition can lead to depression, anxiety, and substance abuse. Many students who start school healthy are far from it by the time they graduate. Some kill themselves.[90]

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[88] Without injunctive relief or damages for Doe's federal-law claims, all that's left of her prayer for relief against the Supreme Court of Kentucky and the Character and Fitness Committee are her attorneys' fees and costs. *See* DN 14-1 at #290. "The litigation must give the plaintiff some other benefit besides reimbursement of costs that are a byproduct of the litigation itself. An interest in attorney's fees is insufficient to create an Article III case or controversy where none exists on the merits of the underlying claim." *Steel Co. v. Citizens for a Better Environment*, 523 U.S. 83, 107 (1998) (quoting *Lewis v. Continental Bank Corp.*, 494 U.S. 472, 480 (1990)) (cleaned up).

[89] 28 U.S.C. § 1367(c)(3).

[90] *See The Suicide of a Law Student Hits Home*, LAWYERS WITH DEPRESSION http://www.lawyerswithdepression.com/articles/the-suicide-of-a-law-student-hits-home/.

Aspiring lawyers should seek the health care they need. But if Kentucky continues to punish people who get help, many won't.[91] And one day, a law student will die after choosing self-help over medical care because he worried a Character and Fitness Committee would use that medical treatment against him — as Kentucky's did against Jane Doe.

It is not a matter of if, but when.

8/28/2020

[91] *See, e.g.*, MADELINE HOLCOMBE, *Law Students Say They Don't Get Mental Health Treatment for Fear It Will Keep Them from Becoming Lawyers*, CNN.COM (Feb. 29, 2020), https://www.cnn.com/2020/02/23/health/law-school-bar-exam-mental-health-questions/index.html.

SmileDirect Decision Reveals Antitrust Risk For State Boards

By Steven Fellman and Richard Bar

Law360 (September 11, 2020, 3:52 PM EDT) --

The new normal developed in response to the coronavirus pandemic has radically changed the way that professional services are provided to consumers.

Steven Fellman

Richard Bar

For many professions, working remotely rather than in an office setting has become pervasive. Virtual physical exams have become commonplace in health care. Virtual education is the norm for students from preschool through graduate school.

In-person testing for professional licensure has largely been replaced by online testing programs. The court systems have moved to utilize Zoom-type depositions and hearings and, in some situations, actual Zoom trials.

How are professional service providers held accountable to meeting the requirements of professional practice amid these drastic changes? In our system of government, state boards often have the responsibility of developing regulations that establish what constitutes minimum requirements for professional practice.

Historically, a majority of the members of such state boards are active, practicing members of the profession that they are regulating. In a wide range of antitrust cases involving highly regulated professions such as — but certainly not limited to — lawyers, doctors and dentists, courts have found that members of state boards are subject to the antitrust laws. In the seminal 2014 decision in North Carolina State Board of Dental Examiners v. Federal Trade Commission, the U.S. Supreme Court held:

When a State empowers a group of active market participants to decide who can participate in its market and on what terms, the need for supervision is manifest. The Court holds today that a state board on which a controlling number of decision makers are active market participants in the occupation the board regulates must satisfy Midcal's [California Retail Liquor Dealer's Association v. Midcal Aluminum, Inc.] active supervision requirement in order to invoke state-action antitrust immunity.

Every state and city has advisory boards and commissions. For example, the city of New York lists more than 300 advisory boards and commissions. Since the time of the North Carolina Dental Examiners decision, the makeup of these boards has been evolving and inclusion considerations have expanded the areas of expertise and interests on state boards.

Many state boards include several consumer representatives to provide user input. State government experts also may be included. And some are dominated by active practitioners, though they may not be aware of the fact that they possibly face personal antitrust liability.

The U.S. Court of Appeals for the Eleventh Circuit's recent decision in SmileDirectClub LLC v. Tanja Battle demonstrates this exposure and the growing, imperative need for attorneys who represent state boards or state board members to review and monitor their clients' activities. This case gives us a fascinating preview or, in the words of dissenting U.S. Circuit Judge Gerald Tjoflat, an advisory opinion of how state board members may be subject to antitrust liability unless state governments carefully supervise their activities.

Summary

SmileDirectClub offers orthodontic treatments at a steep discount compared to typical orthodontists, because unlike the typical orthodontist, it does not provide in-person treatment. SmileDirectClub SmileShops are staffed by dental technicians, not a dentist or orthodontist.

Patient scans are sent to state-licensed dentists who review and identify any periodontal disease, cavities or other oral conditions that would require further investigation or prevent the patient from being a candidate for SmileDirectClub's treatment. If no such problems are present, the dentist writes a patient-specific plan and ultimately a prescription for SmileDirectClub's clear aligners, which are sent to the patient by mail.

The Georgia Board of Dentistry was organized pursuant to Georgia Title 43, Chapter 11 of the Code of Georgia. At the time of this litigation, the board had 11 members, nine of whom were practicing dentists licensed in Georgia. One board member was a dental hygienist and one was a nondental professional. The board had the power to regulate the acts and practices performed by dental hygienists, dental assistants or other persons at the direction of and under the supervision of a licensed dentist.

On Jan. 24, the board voted to amend Rule 150-9-.02, which related to expanded duties of dental assistants. The proposed amendment added conducting digital scans for fabrication of orthodontic appliances and models to the duties of dental assistants that required direct supervision of a dentist.

"Direct supervision" was defined to require a Georgia-licensed dentist to be in the dental office or treatment facility, personally diagnose the condition to be treated, personally authorize the procedures to be done by the dental assistant, remain in the facility while the procedures are being performed, and before dismissal of the patient, evaluate the performance of the dental assistant.

The board sent the proposed amendment to the Georgia governor, who by statute was required to approve, modify or veto the proposed rule amendment.[1] On April 30, 2018, the governor issued a certificate of active supervision to the board approving the proposed amendment "for the purposes of active certification review required by Sec 43-1C-3."

Consequently, SmileDirectClub sued the board and the board members in their individual capacity, alleging antitrust, equal protection and due process violations. The board members filed a Rule 12(b)(6) motion to dismiss the antitrust violations.

The district court denied the motion to dismiss finding that, based on the complaint, there was insufficient evidence to conclude that the Midcal active supervision test had been met. The members of the board appealed to the Eleventh Circuit arguing that, on its face, the certificate of active supervision met the test.

The three judge panel of the Eleventh Circuit issued a 2-1 decision to send the case back to the district court.

Takeaways

The majority opinion by U.S. Circuit Judge R. Lanier Anderson III is of great value to professional associations, state boards and legal practitioners. It begins by discussing the antitrust state-action immunity doctrine of Parker v. Brown, explaining that the Sherman Act applies to individuals but not to action by state governments.

However, the state action immunity doctrine does not allow states to "give immunity to those who violate the Sherman Act by authorizing them to violate it or by declaring that their action is lawful."[2]

Therefore, under the rationale of North Carolina State Board of Dental Examiners. v. FTC, ibid, where a state board is composed of active market participants, the State Board members do not automatically get antitrust immunity. Actions of state boards must meet the Midcal active supervision test.

The Eleventh Circuit court found that, although the governor clearly had the authority to exercise active supervision, there is no evidence that he actually did so. Judge Anderson stated:

There is no indication that the Governor engaged in a substantive review of the amended rule to ensure that it accords with state policy. His comments regarding the proposed amendment in the Certificate of Active Supervision suggest that he only examined the procedural question of whether the amended rule was within the Board of Dentistry's statutory power to propose a rule change. The Governor did not comment—even in passing—on the merits or the contents of the rule change. Quite the contrary. The reasonable inferences from his Certification is that he ascertained that the amendment was within the authority delegated to the Board by the Georgia statute … This is exactly the sort of potential for active supervision—without active supervision—that the Supreme Court has repeatedly held is insufficient to satisfy the active supervision requirement.

This decision should serve as a reminder that, when a new seller enters the marketplace offering a new and cheaper alternative for services or products, the seller may be faced with a situation where a state board or government regulator, based on input from current sellers, decides to curtail the new seller's market access.

In such situations the actions of the members of the state board or advisors to the government regulator may violate the antitrust laws. Many industry and professional groups have tried to hide behind the skirts of government and conspire to keep innovative, lower-priced products and services from the market.

In defending their turf, they may be violating the antitrust laws. Per se antitrust violations such as price-fixing, bid-rigging, customer allocations and some concerted refusal to deal

are felonies. Individuals convicted of such felonies are subject to a minimum jail sentence of one year.

If you have a client serving on a state board or if you advise a state board, you should take necessary steps to ensure that actions of the state board and its members are subject to the type of active supervision described in the SmileDirectClub decision.

This case also highlights the need for state boards to recognize that, where a state board composed of active practitioners is engaging in activities that have a possible anticompetitive affect, even if the state board is created by the legislature and its members are appointed by the governor, antitrust counsel must review the proposed course of conduct to insure that it meets antitrust requirements.

The antitrust review must be by someone who has the specific authority to approve, modify or veto the proposed rule. If this is not done, the individual state board members who established the rule face personal liability, even if their actions have been submitted for approval to another state agency that has supervisory authority.

The SmileDirectClub decision emphasizes that the test is not what the supervisor is authorized to do or even what the supervisor says was done. The test is whether the supervisor made an independent antitrust analysis of the underlying facts and concluded that the proposed action does not violate the antitrust laws.

All states have a person or group in the attorney general's office with specific antitrust responsibilities. It would be prudent to have such a person be given the responsibility of reviewing actions of state boards comprised of active market participants and the authority to approve, modify or veto such actions.

Steven Fellman is of counsel and Richard Bar is a principal at GKG Law PC.

The opinions expressed are those of the author(s) and do not necessarily reflect the views of the firm, its clients, or Portfolio Media Inc., or any of its or their respective affiliates. This article is for general information purposes and is not intended to be and should not be taken as legal advice.

[1] O.C.G.A. Sec 43-1C-3.

[2] 317 U.S. 351.

THE FLORIDA BOARD OF OPTICIANRY

ANNUAL REGULATORY PLAN 2020-21

This Annual Regulatory Plan is being filed and published pursuant to section 120.74, *Florida Statutes* (2019). The Plan covers the period beginning October 1, 2020 and ending September 30, 2021.

PART ONE
LAWS ENACTED OR AMENDED

Part One of the Plan addresses each law enacted or amended during the 2020 Legislative Session which creates or modifies the duties or authority of the Board of Opticianry. §120.74(1)(a), Fla. Stat. (2019).

Law Enacted or Modified on or after Oct. 1, 2019	Florida Statute (modified or created)	Rule (impacted)	Must Agency Adopt Rules?	If Rulemaking is Necessary, Notice of Development Published in Florida Administrative Register?	Expected Publication Date for Notice of Proposed Rulemaking	If Rulemaking is Not Necessary, Explain
Ch. 2020-125, Laws of Florida, Effective July 1, 2020 (HB 115)	§120.82, F.S. §456.0635, F.S. §456.0721, F.S. §456.074, F.S. §1009.95, F.S.	Rule 64B12-9.0015, F.A.C. (Examination for Licensure) Rule 64B12-16.003, F.A.C. (Apprenticeship Requirements and Training Program)	Yes	Unknown	Unknown	N/A

PART TWO

LAWS EXPECTED TO BE IMPLEMENTED THROUGH RULEMAKING

Part Two of this plan addresses those laws which the Board of Board of Opticianry intends to implement through rulemaking by July 1, 2021 that are otherwise not covered pursuant to Part One of this Plan. This Part does not include emergency rulemaking or any other rulemaking that may become necessary that was not evident to the Board at the time of the submission of this plan. Additionally, the listing of a law to be implemented does not mean the rule will necessarily be adopted or effective by July 1, 2021. §120.74(1)(b), Fla. Stat. (2019).

Rule Number and Title	Law Expected to Be Implemented Through Rulemaking	Intent of Rulemaking
64B4-3.003 (Examination for Licensure)	§456.017, F.S.	Clarify, Increase Efficiency
64B12-15 (Continuing Education)	§456.013, F.S. §484.008, F.S.	Clarify, Increase Efficiency

PART THREE
UPDATES TO PRIOR YEAR'S PLAN

Part Three of the Plan address whether there are any updates to the prior year's regulatory plan. §120.74(1)(c), Fla. Stat. (2019).

There are no updates to the prior year's annual regulatory plan.

PART FOUR
CERTIFICATION PURSUANT TO §120.74(1)(d), Fla. Stat. (2018)

The undersigned hereby certify that they have reviewed this Annual Regulatory Plan and that the Board of Opticianry regularly reviews all its rules to determine if the rules remain consistent with the Board's rulemaking authority and the laws being implemented, with the most comprehensive enhanced review having been completed on the 30th day of June 2020 with continuing board review through August, 2020.

_____

/s John B. Girdler
Electronic Signature
John B. Girdler
Chair of the Board of Board of Opticianry

08/21/2020
Date Signed

/s Timothy Frizzell
Electronic Signature
Timothy Frizzell, Esquire
Assistant Attorney General
Counsel to the Board of Board of Opticianry

08/26/2020
Date Signed

RULES REPORT
BOARD OF OPTICIANRY
OCTOBER - 2020

Rule Number	Rule Title	Date Rule Language Approved by Board	Date Sent to OFARR	Rule Development Published	Notice Published	Adopted	Effective
64B12-8.020 64B12-8.024	Disciplinary Guidelines Out-of-State Telehealth Discipline	04/24/2020	07/28/2020	08/12/2020	09/02/2020		
64B12-15.001	Continuing Education for License Renewal	08/03/2020	08/20/2020	09/02/2020	09/21/2020		

New License Report for 2001 : Optician
6/18/2020 - 10/ 9/2020

Sort Order: Original License Date

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Rank	Lic Nbr	Issue Dte	Org / Last	Frst Nme	Mid Nme	Sfx	[redacted]	EDU Provider	EDU Institution	PL Address	PL Location
DO	7453	06/19/2020	Alvarez	Angelique					Adlai E Stevenson	2620 Cara Lynn Way	Longwood, FL 32779
DO	7454	07/02/2020	Oquendo	Daniel					Palm Bay High School	1541 W. New Haven Ave	West Melbourne, FL 32904
DO	7455	07/02/2020	Scott	Jennifer					Del Norte High School	2140 Bloomingdale Ave	Valrico, FL 33596
DO	7456	07/02/2020	Edalgo	John	Mark				Lodi High School	431 Sunnyside Dr	Venice, FL 34293
DO	7457	07/06/2020	Fikes	Alicia						330 N. Alafaya Trail	Orlando, FL 32828
DO	7458	07/06/2020	Morris	Isaac	Markos				Tosson Vocational School	508 Lakewood Dr	Oldsmar, FL 34677
DO	7459	07/08/2020	Williams	Yasmine					Boyd Anderson	9054 Glades Rd	Boca Raton, FL 33434
DO	7460	07/08/2020	Hernandez	Alex					Miami Springs Senior High	7890 W 4Th Lane	Hialeah, FL 33014
DO	7461	07/08/2020	Allen	Bonnie	C				Iaeger High School	7015 Pounding Mill Branch Rd	Pounding Mill, VA 24637
DO	7462	07/10/2020	Hainsworth	Sandra	A					17961 Hwy 441 S.	Summerfield, FL 34491
DO	7463	07/10/2020	German-Barrios	Nuvia	De La Carida				Faculta De Ciencias Medica Dr. Salvador Allende	1600 N. 70Th Terrace	Hollywood, FL 33024
DO	7464	07/10/2020	Rivera Diaz	Natalie					Haines City High School;Hillsborough Community College;Polk State College	2660 E Hwy 50	Clermont, FL 34711
DO	7465	07/14/2020	Gallagher	Darrin					Daytona Beach Community College	1699 N. Wood Land Blvd	Deland, FL 32720
DO	7466	07/16/2020	Greschler	Jedd					Spanish River	9830 Shepard Place	Wellington, FL 33414
DO	7467	07/16/2020	Mirto	Theresa	Angela				North Branford High School	11207 Oakhurst Road	Largo, FL 33774
DO	7468	07/16/2020	Rivera	Brittany					University High School	741 N.Alafaya Trail	Orlando, FL 32828
DO	7469	07/16/2020	Rodriguez Garcia	Evelyn						104 W Vine St Suite C	Kissimmee, FL 34741
DO	7470	07/17/2020	Manning	Steven	Louis				Piper High School	11715 52Nd Rd. N.	West Palm Beach, FL 33411

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DO	7471	07/17/2020	Clark	Cameron	Christopher					27835 Wesley Chapel Blvd Suite 110	Wesley Chapel, FL 33544
DO	7472	07/24/2020	Francis-Bacon	Amy					Green Bay Southwest High School	10060 Us Hwy 301 N. Vision Source	Parrish, FL 34219
DO	7473	07/28/2020	Lapeer	Meggie	Elizabeth Caroline					8509 El Portal Dr	Tampa, FL 33604
DO	7474	07/28/2020	Ham	Robert	James					9965-24 San Jose Blvd	Jacksonville, FL 32257
DO	7475	07/29/2020	Delancy	Kedeisha						4503 W. Atlantic Blvd Apt 1421	Coconut Creek, FL 33066
DO	7476	07/29/2020	Graham	Danielle	Nichole				Excel High School	2637 E. Gulf To Lake Hwy	Inverness, FL 34453
DO	7477	08/04/2020	Goodman	Daniel	Marc				Hyde School	9816 Isles Cay Drive	Delray Beach, FL 33446
DO	7478	08/06/2020	Benaim	Daniela					West Boca Raton High School	20910 Via Oleander #2	Boca Raton, FL 33428
DO	7479	08/17/2020	Janvier	Paule	M				World Hope Academy	5851 Nw 177 St	Hialeah, FL 33015
DO	7480	08/17/2020	Billig	Janet	R.				A.Y. Jackson Secondary School	11 Colonial Way	Livingston, NJ 07039
DO	7481	08/17/2020	Marsh	Christopher	Daniel				Freedom High School	11212 Park Blvd N.	Seminole, FL 33772
DO	7482	08/18/2020	Williams	Chalaine					Piper High School	4577 Weston Rd	Weston, FL 33331
DO	7483	08/19/2020	Kasap	Emily					Lorenzo Walker Technical College	5455 Tamiami Trail N. Suite B5	Naples, FL 34108
DO	7484	08/25/2020	Kim	Shery					Wilson High School	2225 Grand Cypress Dr.	Lutz, FL 33559
DO	7485	08/25/2020	Ruiz	Christopher	J				Jp Taravella	706 W. Boynton Beach Blvd	Boynton Beach, FL 33426
DO	7486	08/27/2020	Garcia Rodriguez	Christopher	A				Freedom	4795 W. Irlo Bronson Mem Hwy	Kissimmee, FL 34746
DO	7487	08/31/2020	Gamboa	Campie	Alicia			High School (In State)	Melbourne High School	110 Easy Street	Sebastian, FL 32958
DO	7488	09/09/2020	Mendoza	Gema	De La Caridad				Carlos Marx (Cuba)	5790 W 17 Ct	Hialeah, FL 33012
DO	7489	09/12/2020	Kish	Troy	David				Sandwich Community High School	2440 Allegro Av.	Spring Hill, FL 34609

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Rank	Lic Nbr	Issue Dte	Org / Last	Frst Nme	Mid Nme	Sfx	[redacted]	EDU Provider	EDU Institution	PL Address	PL Location
DO	7490	09/20/2020	Stenger	Melissa						2709 Marlette St	Sarasota, FL 34231
DO	7491	09/20/2020	Rodriguez	Ylsa					Flanagan High School	16141 Blatt Blvd Apt 104	Weston, FL 33326
DO	7492	09/20/2020	Shapiro	Deborah	Lynne				Finneytown High School	404 Cerromar Circle North Apt 208	Venice, FL 34293
DO	7493	09/21/2020	Bautista	Lyndon					Forest Park	7008 West Colonial Dr.	Orlando, FL 32818
DO	7494	09/22/2020	Donofrio	Amanda						10991 San Jose Blvd Suite 32	Jacksonville, FL 32223
DO	7495	09/22/2020	Fanjul	Christian					Hillsborough Community College;Miami Palmetto Senior High	7370 Pinnacle Pines Dr Apt - D1	Fort Myers, FL 33907
DO	7496	09/22/2020	Lopez	Elizabeth	C				El Camino Real High School	8433 Southside Blvd Apt 2402	Jacksonville, FL 32256
DO	7497	09/22/2020	Miller	Carly					Clearwater High School	2655 Gulf To Bay Blvd	
DO	7498	09/22/2020	Rodriguez	Talisa						948 Slocum St Nw	Palm Bay, FL 32907
DO	7499	09/22/2020	Hering	Jack					South Shore High School	133 Nw 14Th St	Boynton Beach, FL 33426
DO	7500	09/24/2020	Richards	John					Gateway Regional	3631 Falking Acorn Circle	Lake Mary, FL 32746
DO	7501	09/25/2020	Sepulveda Cruz	Zuleyka	M				Ines Maria Mendoza	10017 Hidden River Dr 204	Orlando, FL 32829
DO	7502	09/25/2020	Hernandez Castrillo	Alina					I.P.U. Raquel Perez Gonzalez	20711 Sw 80Th Ct	Cutler Bay, FL 33189
DO	7503	09/28/2020	Lopez	Katia					Champagnat Catholic School	620 Sw 44Th Ave	Coral Gables, FL 33134
DO	7504	09/29/2020	Pena	Paola	M				Miami Jackson Senior Highschool	1517 Nw 32 St	Miami, FL 33142
DO	7505	10/06/2020	Katz	Nicole					Apopka High School	West S.R. 46 And Upsala Rd	Sanford, FL 32771
DO	7506	10/07/2020	Knox	Stephen	K				Lindbergh High	3641 S. Clyde Morris Blvd	Port Orange, FL 32129

Total Records: **54**

MQA Reports
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Rank	Lic Nbr	Issue Dte	Org / Last	Frst Nme	Mid Nme	Sfx	[redacted]	EDU Provider	EDU Institution	PL Address	PL Location
DA	8961	06/30/2020	Henry	Gregory	Scott				Pasco High School	33233 Old St Joe Road	Dade City, FL 33525
DA	8962	07/01/2020	Naelitz	Aleena					Woodland High School	330 North Alafaya Trail	Orlando, FL 32828
DA	8963	07/07/2020	Greenwood	Courtney	Anne				Daytona State College	524 Canal Street	New Smyrna Beach, FL 32168
DA	8964	07/07/2020	Lopez	Stephen	M				Christopher Columbus	4120 Del Prado Blvd South	Cape Coral, FL 33904
DA	8965	07/09/2020	Silvestre	Christian						1020 Lockwood Blvd	Oviedo, FL 32765
DA	8966	07/10/2020	Aligada	Jenny	J					6950 Central Ave	Saint Petersburg, FL 33707
DA	8967	07/17/2020	Piper	Amy	Leigh				Pine Ridge High School	1108-C S Dale Mabry Hwy	Tampa, FL 33629
DA	8968	07/20/2020	Hemingway	Brittany					Gateway Charter High School	2891 12Th Ave Ne	Naples, FL 34120
DA	8969	07/22/2020	Melo	Andy					Port St Lucie Highschool	5406 Nw Woodland Way	Saint Lucie West, FL 34986
DA	8970	07/24/2020	Diaz Lima	Daileny						3920 A W. Hillsborough Ave	Tampa, FL 33614
DA	8971	07/24/2020	Milowitz	Priscilla	Ann				Wesley Chapel Highschool	6812 Gideon Circle	Zephyrhills, FL 33541
DA	8972	07/31/2020	Cole	Jennifer	Lynn				Escambia County High School	3101 Highway 97	Molino, FL 32577
DA	8973	08/05/2020	Maldonado Diaz	Daniel					Ged	5700 Nw 23Rd Street	Gainesvillegainesvil, FL 32653
DA	8974	08/07/2020	Oliva	Kathy	Ines					91284 Overseas Hwy.	Tavernier, FL 33070
DA	8975	08/18/2020	Gorrell	Beth					Perkins High School	3334 Spotted Fawn Drive	Orlando, FL 32817
DA	8976	08/22/2020	Lang	Keelee	Madison					1590 Dunlawton	Port Orange, FL 32127
DA	8977	08/22/2020	Villar Santos	Annalie					Republica De Argelia	1540 Ne 191St St	Miami, FL 33179
DA	8978	08/26/2020	Ketchum	Aviana					Fort Pierce Central High	1115 Vidina Place Suite 125	Oviedo, FL 32765
DA	8979	08/26/2020	Pena Gonzalez	Llitsi						2144 W. Indian Town Road	Jupiter, FL 33458
DA	8980	08/26/2020	Zotamba	Gina	Paulina					3817 E. Colonial Dr	Orlando, FL 32803

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DA	8981	08/31/2020	Rivera	Maricely					Academia Maria Reina	1137 Sw 147Th Terrace	Pembroke Pines, FL 33027
DA	8982	08/31/2020	Truenski	Timothea						5763 Sabal Trace Drive Unit 101	North Port, FL 34287
DA	8983	08/31/2020	Baltazar	Julissa						2101 S. Parrott Ave	Okeechobee, FL 34974
DA	8984	08/31/2020	Mattiuz	Jill					East Bay High School	4405 Mcgee Road	Plant City, FL 33565
DA	8985	09/01/2020	Fredrick	Peri					The Bolles School	4712 River City Dr Space 107	Jacksonville, FL 32246
DA	8986	09/02/2020	Ford	Michael					Pinellas Technical College	4700 S Flamingo Rd.	Cooper City, FL 33330
DA	8987	09/08/2020	Garcia	Amanda	Monique				World Hope Academy	1431 S.E 24 Ct	Homestead, FL 33035
DA	8989	09/09/2020	Perez Rodriguez	Alexa						1707 Nw St. Lucie West Blvd Suit 184	Port Saint Lucie, FL 34986
DA	8990	09/09/2020	Gonzalez	Anniuska						3200 Old Boynton Road	Boynton Beach, FL 33436
DA	8991	09/10/2020	Ortiz	Karla	M					2517 Ne 10Th Court	Homestead, FL 33033
DA	8992	09/12/2020	Dreizin	Svetlana					Ps# 98	7824 North Fork Drive	West Palm Beach, FL 33411
DA	8993	09/17/2020	Flores	Katherine	Lizzette					2811 E. Irlo Bronson Memorial Hwy	Kissimmee, FL 34744
DA	8994	09/19/2020	Antoine	Mirline						17650 N W 2Nd Ave	Miami, FL 33169
DA	8995	09/19/2020	Plasencia	Maria	Del Mar					18506 Nw 186 St	Hialeah, FL 33015
DA	8996	09/19/2020	Ferrer	Elianna						18506 Nw 186 St	Hialeah, FL 33015
DA	8997	09/20/2020	Barrett	Austin	Waldiman				Ocoee High School	8889 West Colonial Drive	Ocoee, FL 34761
DA	8998	09/23/2020	Salinas	Jose	J				Escuela Virtual De Puerto Rico	8431 Sw 102 Ct	Miami, FL 33173
DA	8999	09/25/2020	Terrell	Tia	Monique					2951 S. Blue Angel Pkwy	Pensacola, FL 32506
DA	9000	09/25/2020	Rullan	Mishelle	Marie					2811 E. Irlo Bronson Memorial Hwy	Kissimmee, FL 34744

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DA	9001	09/25/2020	Cabano Naqvi	Carla	Daniella					101 N. Congress Ave	Lake Park, FL 33403
DA	9002	09/26/2020	Sirotzky	Sara						14832 S.W 62 St	Miami, FL 33193
DA	9003	09/29/2020	Paul	Savannah	Lynn					928 W. New Haven Ave	Melbourne, FL 32901
DA	9004	09/29/2020	Westfall	Stephanie	Ellen					928 W. New Haven Ave	Melbourne, FL 32901
DA	9005	09/29/2020	Kirkley	Camden	Lee				Palmetto Ridge High School	2628 2628 Tamiami Trail North	Naples, FL 34103
DA	9006	10/02/2020	Bailey	Kristen					Ged	5790 W Grover Cleveland Blvd	Homosassa, FL 34446
DA	9007	10/06/2020	Jackisch	Kaitlin					Seminole High School	3740 Park Blvd N	Pinellas Park, FL 33781
DA	9008	10/06/2020	Tenen	Shannon					Gateway High	963 Tramells Trl	Kissimmee, FL 34744
DA	9009	10/06/2020	Carver	Chelsea	Ann					6868 Us Hwy 129	Live Oak, FL 32060
DA	9010	10/06/2020	Mcguyre	Kasey	N				Santa Rosa Adult High	3960 Navy Boulevard St 1	Pensacola, FL 32507
DA	9011	10/07/2020	Hinojosa	Alessandra	V					15284 Sw 119 St	Miami, FL 33196
DA	9012	10/08/2020	Baer	Valerie					Canastota	4230 Lee Hall Place	Cocoa, FL 32927
DA	9013	10/08/2020	Hernandez	Liang				High School (Out Of State)		12320 S Cleveland Ave	Fort Myers, FL 33907

Total Records: **52**

108 CE Courses Approved – June 17, 2020 through October 9, 2020

Provider Name	Provider #	Course Name	Course #	Status
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - What's Your Quality Improvement Strategy?	20-707429	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - Engage, Amaze & Convert; Using Technology to Grow Sales	20-786132	APPROVED
FOCAL EDUCATION LLC.	50-5300	Frame Manufacturing, Past, Present and Future Video Presentation Home Study	20-785458	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Basic Principals of Refraction	20-710933	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - Abbe Value & Reflective Index - The Ongoing Battle	20-707439	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - What's Your Retail V.I.B.E?	20-709995	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - Laws and Rules (Update) VIDEO PRESENTATION	20-707421	APPROVED
QUANTUM OPTICAL, INC	50-4752	Pediatric Dispensing	20-714349	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - It's Amazing How Something So Small Can Make Such a Big Impact. Unity BioSync Contact Lenses	20-707425	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Photochromic and Polarized Lenses: Better Together	20-697365	APPROVED
FOCAL EDUCATION LLC.	50-5300	Specialty Contact Lens Basics Video Presentation Home Study	20-709131	APPROVED
QUANTUM OPTICAL, INC	50-4752	Lets Build a Brand Together	20-713739	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - Light Management: The Need for Ocular Solutions	20-707251	APPROVED
QUANTUM OPTICAL, INC	50-4752	Dot Your I's and Cross Your T's	20-713741	APPROVED
QUANTUM OPTICAL, INC	50-4752	Mixing It Up - Frame Materials	20-713715	APPROVED
QUANTUM OPTICAL, INC	50-4752	Making Glasses Easy To Buy and Sell	20-713699	APPROVED
QUANTUM OPTICAL, INC	50-4752	Lens Aberration- The Villain In Plain Sight	20-713717	APPROVED
QUANTUM OPTICAL, INC	50-4752	Contact Lens Space Exploration	20-713755	APPROVED
OPTICAL TRAINING INSTITUTE	50-11306	Anatomical Structures and Soft Contact Lenses	20-702843	APPROVED

FOCAL EDUCATION LLC.	50-5300	How to Turn Difficult Patients into Happy Patients. Video Presentation Home Study	20-785040	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Pillars of Customer Service	20-784074	APPROVED
QUANTUM OPTICAL, INC	50-4752	Down With OPP Optician Physics Principles	20-713719	APPROVED
QUANTUM OPTICAL, INC	50-4752	Swimming in Contact Lenses	20-713735	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - Blue Light, Ultra-Violet Radiation, and the Human Eye	20-707459	APPROVED
CEDO INC	50-442	Optical Disorders & The ECP HS	20-783224	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - Blue Light Radiation, A Material Solution	20-707447	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - Finding The Power In Any Meridian	20-709167	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - Ocular Conditions and Their Systemic Link	20-783934	APPROVED
QUANTUM OPTICAL, INC	50-4752	Game Over for Gamer Eyestrain	20-713723	APPROVED
QUANTUM OPTICAL, INC	50-4752	Your Signature	20-713721	APPROVED
QUANTUM OPTICAL, INC	50-4752	Revealing the Gaps Between Luxury Eyewear, Designer Brands and Value Frames	20-713777	APPROVED
QUANTUM OPTICAL, INC	50-4752	Low Vision	20-713691	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Troubleshooting Optical Problems	20-708205	APPROVED
QUANTUM OPTICAL, INC	50-4752	Troubleshooting Eyewear Adaptation Issues	20-713785	APPROVED
FLORIDA OPTOMETRIC ASSOCIATION	50-2499	The ABCs of Pediatric Eye Care	20-779958	APPROVED
FLORIDA OPTOMETRIC ASSOCIATION	50-2499	Service with a Smile	20-781546	APPROVED
FOCAL EDUCATION LLC.	50-5300	Contact Lens Complications Video Presentation Home Study	20-785064	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - Advanced Ophthalmic Optics	20-707455	APPROVED
FOCAL EDUCATION LLC.	50-5300	Dry Eye and Contact Lens Drop Out Video Presentation Home Study	20-783614	APPROVED
QUANTUM OPTICAL, INC	50-4752	Avoid Meeting Meltdown	20-713747	APPROVED
QUANTUM OPTICAL, INC	50-4752	Connect First Then Validate Using Social Proof!	20-714345	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - Treatment and Control of Myopia	20-707415	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Mastering Prism	20-707031	APPROVED
QUANTUM OPTICAL, INC	50-4752	It's Not a Contact Lens Power Trip	20-713759	APPROVED

QUANTUM OPTICAL, INC	50-4752	Emotional Intelligence in the Dispensary	20-713687	APPROVED
QUANTUM OPTICAL, INC	50-4752	Demystify The Managed Care Plan and Capture More Revenue	20-714285	APPROVED
FOCAL EDUCATION LLC.	50-5300	Psychology of Effective Communication with Your Patients	20-707083	APPROVED
FOCAL EDUCATION LLC.	50-5300	When Single Vision Isn't Enough Video Presentation Home Study	20-785042	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Eyewear Trends & Selection Techniques	20-785034	APPROVED
FOCAL EDUCATION LLC.	50-5300	The Sleeping Giant of Multiple Pair Sales Video Presentation Home Study	20-785046	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - Finding the Style in Lenses	20-709989	APPROVED
FOCAL EDUCATION LLC.	50-5300	Customer Service: The Essential Extra Mile Video Presentation	20-708731	APPROVED
QUANTUM OPTICAL, INC	50-4752	Ophthalmic Optics - Basics to Build On	20-713713	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - Beyond Clear - Five Latest Innovations in Photochromic	20-783730	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - New Photochromic Lens Technology Expanding Material, Casting, Coating Options	20-707449	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - Camber Technology - The Next Generation of Digital Progressive Lenses	20-709181	APPROVED
QUANTUM OPTICAL, INC	50-4752	Fifteen Amazing Concepts to Share with Your Patients	20-713783	APPROVED
QUANTUM OPTICAL, INC	50-4752	I Cant Wear My Contacts!	20-713757	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Eyezen Start	20-779802	APPROVED
QUANTUM OPTICAL, INC	50-4752	Optical Polarization	20-714337	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - How to Achieve 50% Multiple Pair Sales	20-786128	APPROVED
QUANTUM OPTICAL, INC	50-4752	Optical Prism	20-714339	APPROVED
QUANTUM OPTICAL, INC	50-4752	Let There Be Light	20-713765	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - Mastering Prism	20-707451	APPROVED
QUANTUM OPTICAL, INC	50-4752	Precision Matters	20-790270	APPROVED
FOCAL EDUCATION LLC.	50-5300	Dispensing with Confidence, How to Avoid Dispensing Mistakes. Video Presentation Home Study	20-785038	APPROVED

FOCAL EDUCATION LLC.	50-5300	Kids Can Wear Contacts Too Part 2 Orthokeratology & Myopia Control Video Presentation Home Study	20-708841	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - What's This Light Thing?	20-786326	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - X, Y, Z Boom. Eyecare for Every Generation	20-707435	APPROVED
QUANTUM OPTICAL, INC	50-4752	Understanding Astigmatism and How it Affects Contact Lens Wear	20-790266	APPROVED
QUANTUM OPTICAL, INC	50-4752	Basic Slit Lamp	20-713751	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	New Photochromic Lens Technology Expanding Material , Casting, Coasting Options	20-706959	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Advanced Ophthalmic Optics	20-783554	APPROVED
QUANTUM OPTICAL, INC	50-4752	Our Eyes and Damaging Light	20-713749	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - UV vs Blue	20-707255	APPROVED
OPTICAL TRAINING INSTITUTE	50-11306	Orthokeratology and Myopia Control	20-711405	APPROVED
FOCAL EDUCATION LLC.	50-5300	Myopia Control Home Study Course	20-708973	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	What's this Light Thing?	20-785276	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - What's New in Contact Lenses	20-708453	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - Eyezen Start	20-708399	APPROVED
FLORIDA OPTOMETRIC ASSOCIATION	50-2499	Binocular Harmonization Technology (BHT)	20-783322	APPROVED
QUANTUM OPTICAL, INC	50-4752	Contact Lens Complications Presentation and Management	20-714287	APPROVED
QUANTUM OPTICAL, INC	50-4752	Prism Proficiency	20-713743	APPROVED
CEDO INC	50-442	Management & Leadership Skills for the ECP	20-783222	APPROVED
FOCAL EDUCATION LLC.	50-5300	Scleral Contact Lens Fitting Video Presentation Home Study	20-710221	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Blue Light, Ultra-Violet Radiation, and the Human Eye	20-707035	APPROVED
FOCAL EDUCATION LLC.	50-5300	Gas Permeable Contact Lens Fitting	20-707087	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - The Technology and Benefits of Polarized Lenses	20-709177	APPROVED
QUANTUM OPTICAL, INC	50-4752	Scleral Lenses - The Basics	20-713779	APPROVED
QUANTUM OPTICAL, INC	50-4752	A 3-Point Touch on Soft Contact Lenses	20-714293	APPROVED

FOCAL EDUCATION LLC.	50-5300	Kids Can Wear Contacts Too Video Presentation Home Study	20-785048	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - Quality Ophthalmic Frame Construction	20-707461	APPROVED
QUANTUM OPTICAL, INC	50-4752	Lower Your Expectations - Embracing Best Corrected Visual Acuity	20-713745	APPROVED
FOCAL EDUCATION LLC.	50-5300	UV vs Blue Video Presentation Home Study	20-785044	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Big Needs for Little People	20-709187	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - Tips For Toddlers - Best Practices For Pediatric Dispensing	20-783846	APPROVED
QUANTUM OPTICAL, INC	50-4752	Can You Cut It	20-714283	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Reduction of Medical Errors (Video Version)	20-786610	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - MR Material; Strong, Thin, with Visual Appeal and Integrity	20-707441	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - Harmful Blue Light and Optical Solutions for Long Term HEV Protection	20-785218	APPROVED
QUANTUM OPTICAL, INC	50-4752	Lens Materials Mater To Me	20-714291	APPROVED
QUANTUM OPTICAL, INC	50-4752	CATS - Cataract Formation and Contact Lenses	20-713727	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Florida Laws & Rules	20-708203	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - Mastering Luxury Eyewear Materials	20-707257	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Anterior Ocular Pathology	20-709189	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Mastering Luxury Eyewear Materials Hands-on Workshop	20-707235	APPROVED
PROFESSIONAL OPTICIANS OF FLORIDA	50-1645	Home Study - Photochromic and Polarized Lenses: Better Together	20-707413	APPROVED
QUANTUM OPTICAL, INC	50-4752	Slit Lamp & Contact Lenses	20-714281	APPROVED

Course Summary

CEDO INC

Course # 20-716013 - Can Nutrition Reverse Diabetes & its Causation of Eye Disease?

CE Committee Review Comments:

Board Review Required. Review by the board for time. Seems more likely a 1-hr course than a 2-hr course.

Course Addition Request

Course Name	Can Nutrition Reverse Diabetes & its Causation of Eye Disease?-HS
CE Broker Course Tracking #	20 - 716013
Course Description	This course will show the latest in Research and Science for the use of alternative methods in controlling or even reversing Diabetes and therefore Blindness related to Diabetes.
Provider	CEDO INC
Course Type	Anytime
Delivery Method	Home Study
Provider Type	Board Approved Provider

Profession Selection + Hours	Renewal Hours	Approved Hours
Optician		
HIV/AIDS	0	
Medical Errors	0	
Technical Practice	2	
Elective	0	
Technical Practice (Contact Lens Theory and Practice)	0	
Laws and Rules of the Board (Initial Licensure or Renewal)	0	
Laws and Rules of the Board (Renewal Only, not for Initial Licensure)	0	
Laws and Rules of the Board (Apprentice Orientation)	0	
20-hour Board Certification Course (not taken to obtain Board Certification)	0	

Can Nutrition Reverse Diabetes & its Causation of Eye Diseases?

J David Wood LDO, BSJ

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Can Nutrition Reverse Diabetes & its Causation of Eye Diseases?

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Course Description: (2 hours)

This course will look at Diabetes and its role in Eye Disease. This is meant to reveal the latest research about the possibilities of how to help those with pre-diabetes and type 2 diabetes to heal or at least improve. Science/Research has even stated there may be some help with these methods for Type 1 diabetes. I also want to provide the ECP *(Eyecare Professional)* a review and discussion to understand how and therefore why diabetes affects the eye so severely to even cause blindness.

In the second part of this course, I will show how the diabetic can reverse the disease and thereby avoid most of the issues discussed in part I. An emphasis will be made on how to help the patient understand the meaning of the medical terms the Doctor used to tell them about their diabetes and their eyecare. Sometimes these medical terms do not mean enough to the Patient because they are not explained in layman's terms and the patient can end up in harm's way because they did not understand what they were to look for or to do.

I also explain how the ECP needs a great understanding of the proven lifestyle changes that will help reverse the effects of diabetes on the eye and the possibility of even curing the diabetes and therefore the eye diseases associated with it. We as Opticians can direct and refer to those who have more credentials if we understand the issues ourselves. This is something we can suggest to the patient to read and understand their case better and be able to know what might help them. We of course will not step outside the boundaries of our practice of Opticianry, but at all times work with the Doctor. If we do the research and show this to others, we are not practicing as Doctors, only showing the professional opinions and proven results with research of those with the proper credentials.

Instructional Objectives

Upon conclusion of this course, the student will be able to:

- Define what Diabetes is.

- Explain the 3 different types of Diabetes and how the newest type can develop into Glaucoma.
- Define Insulin sensitivity vs resistance
- Define Leptin sensitivity vs resistance
- Discuss the Columbia University findings on how human gut cells can be converted into cells that produce insulin in response to dietary sugar.
- List the Statistics of how many people in the USA have Diabetes or prediabetes, and what the future holds for more.
- List and explain the four Eye diseases associated with Diabetes.
- Discuss the types of food for a healing diet, how much fat, protein and carbohydrates to eat.
- Discuss the role that exercise has in reversing diabetes
- Describe the brain connection to type 3 diabetes and how it can induce Glaucoma
- Explain the Leptin connection and how weight loss will improve conditions.
- Explain how the Optician can help in the referral process by understanding the nutritional needs to help heal the patient.
- Discuss the foods and supplements that help slow or stop Diabetes
- List the Three herbs that researchers/science has accepted to help diabetics

Now, before we start this course lets address the elephant in the room…

FDA disclaimer

The information provided in this course has not been evaluated by the United States Food and Drug Administration and is not approved to diagnose, treat, cure or prevent disease. It is for informational purposes only and is not intended as a substitute for advice from your physician or other health care

professional. You should not use this information for diagnosis or treatment of any health problem or for prescription of any medication or other treatment.

You should consult with a healthcare professional before taking any medication or supplements, especially if you are pregnant or if you have or suspect you might have a health problem.

Introduction…

I think most everyone has heard the old adage of "you are what you eat"? This came about around 1930 when American nutritionist Victor Lindlahr, who was a strong believer in the idea that food controls health, developed the Catabolic Diet. I know of three others of the 1920s-1930s who were also advocates of nutrition, namely Norman Walker, Paul Bragg and Jack Lalanne who lived to 102, 95, and 96 respectively. We were already about 30 years into this newer medical discovery of pharmaceuticals. And yes, these nutrition advocates were advocating for people to go back to regenerative farming and nutritional diets of yesteryear. This was in direct contrast to the processed/fast food diets that were already being pushed on us at the grocery stores and the foods grown with the new chemical fertilizers and chemical herbicides and pesticides. (and this was 1920s-1930s!)

Jack Lalanne even said *"People thought I was a charlatan and a nut. The doctors were against me—they said that working out with weights would give people heart attacks and they would lose their sex drive."* So we see this same attitude among some doctors today when we talk diet and nutrition. Trivia: When Jack Lalanne was 54 years young, he was in a competition that he won against a 21 year old Arnold Schwarzenegger.

This course is a presentation of how we may be able to heal the root causes of disease (in this case diabetes), and not just mask the symptoms or "control" the symptoms with pharmaceuticals.

This course will present the parts of the "Alternative" medical systems that science has proven to work, including regulation of certain diets, exercise and vitamins and supplements that are food based and herbal based. Remember as you read this that most of the doctors in the US are not trained in medical school for nutrition and there is little to no training in herbal. Yet many other countries rely on the ancient medicine and actually some of those communities are living longer and in better health than the US population.

We in the US have depleted our soil so badly with chemical fertilizers and chemical herbicides and pesticides that poison the ground and as the end result, poison humans. Therefore the nutrition is not as great in our vegetables and fruits, nor are we eating healthy meats raised in

the old way of regenerative farming. (Europe calls it Biodynamic Farming) With this concept in mind I intend to show you a way we may be able to prevent blindness through these methods.

I have mentioned regenerative farming twice now, and for those that would like to know what it is, please go to the reference section under “regenerative farming” and see the You Tube video movie clip of a new movement for this type of farming.

Before the new age of processed and fast foods came out around 1900, the US had very few cases each year of diabetes and other diseases like macula degeneration only had a couple of cases from 1851 to 1920. So lets see why these cases are now into the millions.

As you read this course I believe most of you will know somebody who has diabetes or at least prediabetes. In fact you may have been diagnosed with this yourself! We have all heard the term “diabetes” for years, yet some will not know the root cause of diabetes. I intend to explain the root cause so you will see the possibility of a reversal or cure by the time we wrap up this course. Some of the discussion about what causes diabetes has changed dramatically over the last 5 or 6 decades. I for one experienced a diagnosis with diabetes in the mid 1970s and at that time was told there is no cure and that the only control for diabetes was insulin. I didn’t believe that, so I hypothesized that diet and exercise would help and the science proves me right after many years. (We did not have the research then to prove what we know now)

Today, you will find some doctors trying to help control at least pre-diabetes with a lifestyle change. These are the same doctors not trained in nutrition that have surged ahead to learn more on their own about how to help their patients with diabetes. I want to show proof of this lifestyle change and how most anybody with the will power and self discipline can take an honest look at themselves and move ahead to stop the damage to their eyes and even prevent blindness. I will only report the proven science as you will see in my references. So let’s get started! (you will see links in my references for further study for those so energetic)

What is diabetes?

Before we get into the nitty-gritty of causes, prevention, and possibly reversal of diabetes, let's clarify and define some terms that you may or may not be so familiar with. For example… the difference between type 1 and type 2, and the emergence of what some are now referring to as "type 3" diabetes. The terms "pre-diabetes" and "metabolic syndrome", and “sensitivity” vs “resistant” also need to be explained.

Understanding how Insulin operates…

Insulin attaches to a receptor on the surface of muscle tissue and drives a complex change within the interior compartment of the tissues which allows glucose to enter.

Insulin Sensitivity

Tissue responsiveness to insulin, meaning how successfully the receptor operates to permit glucose clearance, is termed insulin sensitivity. In the case of optimal insulin sensitivity, after a high sugar meal, insulin rises sharply, pushing glucose into the tissues rapidly, then dissipates. In the case of poor insulin sensitivity, however, insulin's elevation is sustained due to an inability to force glucose into muscle tissues. The consequences are poor receptor sensitivity which indicates a failure in the communication between insulin and the internal cellular machinery. Locked out of the muscles, glucose remains elevated in circulation. Because glucose remains high, the pancreas must generate additional insulin or insulin will need to be injected to complete circulatory glucose disposal.

Insulin Resistance

Abnormally low insulin sensitivity is called insulin resistance. In this case, tissues resist the activity of insulin on a regular basis, disabling efforts to remove glucose from circulation and eventually requiring medical intervention.

Disease Risk

Insulin resistance also occurs at the liver and adipose tissues. When these tissues do not properly respond to insulin, glucose and fat are released into circulation. Sustained elevation of circulatory glucose and triglycerides cause cardiovascular diseases and obesity.

• **Pre-diabetes**, also known as impaired glucose tolerance, describes an earlier state of progressing insulin resistance. It is conventionally diagnosed by having a fasting blood sugar between 100 and 125 mg/dl.

• **Metabolic syndrome**. As your insulin resistance progresses, your liver makes too much sugar and fat, and your skeletal muscles are less able to burn them and make glycogen, which is how glucose is stored in your muscles and liver. In turn, there is an increase in sugar and fats in your bloodstream which leads to high triglyceride levels and increased body fat--especially abdominal fat, and higher blood pressure.

Having 3 or more of a group of symptoms caused by insulin (and now we also know leptin) resistance -- high triglycerides, low HDL, higher blood glucose and blood pressure, and increased belly fat—is referred to as metabolic syndrome (in the past it was called Syndrome X).

• **Type 1: insulin-dependent diabetes**. Traditionally, type 1 diabetes develops before the age of 20. It used to be relatively uncommon, but its incidence is rapidly rising.

Type 1 diabetes is classically an autoimmune disease in which your immune system destroys the insulin-producing cells of your pancreas, resulting in an inability to produce any significant insulin which that, if left untreated, will cause death in days to weeks from a hyperglycemic coma.

This deficiency of insulin is why type 1 is called "insulin-dependent" diabetes. There is currently no known way to completely reverse this, only how to help it.

However recent research suggests glimmers of hope. For example, Columbia University scientists claim that by turning off a particular gene, human gut cells can be converted into cells that produce insulin in response to dietary sugar.

• **Type 2: non-insulin-dependent diabetes**. In type 2 diabetes, the pancreas is producing some insulin, in fact usually too much, but is unable to recognize the insulin and use it properly. This is an advanced stage of insulin resistance, which is typically caused by a diet that is too high in sugars and sugar-forming foods.

When you have inadequate insulin signaling, sugar cannot get into your cells and instead builds up in your blood. While anyone can get type 2 diabetes, you are typically considered at highest risk if you are overweight, sedentary, you are a woman who had gestational diabetes, have family members with type 2 diabetes, or have metabolic syndrome. However, all of these really have the same underlying root of insulin and leptin resistance as I will show you.

Type 2 diabetes represents the vast majority of all diabetics, and contrary to conventional medical and media teaching, it's nearly 100 percent reversible, through lifestyle changes alone, providing these are instituted before the progression of the disease kills the cells in the pancreas that makes insulin, causing type 1 diabetes too; see second part of this discussion.

• **Type 3: non-insulin-dependent diabetes.** A growing body of research suggests there's a powerful connection between your diet and your risk of both Alzheimer's disease and glaucoma, via similar pathways that cause type 2 diabetes. Alzheimer's disease was tentatively dubbed "type 3 diabetes" in early 2005 when researchers learned that the pancreas is not the

only organ that produces insulin. Your brain also produces insulin, and this brain insulin is necessary for the survival of your brain cells.

A drop in insulin production in your brain may contribute to the degeneration of your brain cells, and studies have found that people with lower levels of insulin and insulin receptors in their brain often have Alzheimer's disease. Researchers have now discovered that insulin does far more than simply regulating blood sugar. Your brain does not require glucose, and actually functions better burning alternative fuels, especially ketones. In fact, Dr. Rosedale believes that it is the constant burning by the brain of glucose that is primarily to blame for Alzheimer's and other brain disorders

Insulin is actually a "master multitasker" that helps with neuron glucose-uptake, and the regulation of neurotransmitters, like acetylcholine, which are crucial for memory and learning. This is why reducing the level of insulin in your brain impairs your cognition. Other research shows that type 2 diabetics lose more brain volume with age than expected—particularly gray matter. This kind of brain atrophy is yet another contributing factor for dementia. "Brain diabetes" may also be responsible for glaucoma, according to recent research. As reported by Medical News Today.

"Researchers [in India]... have proposed a new mechanism of glaucoma which suggests that diabetes can occur in the brain and may be the cause of many neurodegenerative disorders including glaucoma... an irreversibly blinding disorder with almost 65 million sufferers worldwide. There is no cure...”

The recent paper titled 'Glaucoma: Diabetes of the brain - a radical hypothesis about its nature and pathogenesis', also published in Medical Hypotheses... explores glaucoma and related neurodegenerative diseases from many perspectives and come up with a multifaceted and internally coherent concept of glaucoma being 'the diabetes of the brain."

It's becoming increasingly clear that the same pathological process that leads to insulin resistance and type 2 diabetes may also hold true for your brain. As you over-indulge on sugar and grains, your brain becomes overwhelmed by the consistently high levels of glucose and insulin that blunts its insulin signaling, leading to impairments in your thinking and memory abilities, eventually causing permanent brain damage.

Additionally, when your liver is busy processing fructose (which your liver turns into fat), it severely hampers its ability to make cholesterol, an essential building block of your brain that is crucial for optimal brain function. Indeed, mounting evidence supports the notion that significantly reducing fructose consumption is a very important step you can take to prevent Alzheimer's disease.

Statistics: Why are the numbers rising so fast?

Great Britain, like the United States, has seen a remarkably rapid rise in pre-diabetes and type 2 diabetes over the last decade. According to a recent BBC News report, more than one-third of British adults are now pre-diabetic.

In 2003, 11.6 percent of Britons had pre-diabetes. By 2011, that figure had more than tripled, reaching 35.3 percent. Researchers warn that this will lead to a massive avalanche of type 2 diabetics in upcoming years, which will have serious consequences for health care and life expectancy.

In the United States, nearly 80 million people, or one in four has some form of diabetes or pre-diabetes (2014), now that was 6 years ago, so what would the percentage be today? What's worse, both type 1 and type 2 diabetes among children and teens has also skyrocketed.

The most recent data, reveals that, between 2001 and 2009, incidence of type 1 diabetes among children under the age of 19 rose by 21 percent. Incidence of type 2 diabetes among children aged 10-19 rose by 30 percent during that same timeframe!

What is diabetic eye disease?

Diabetic eye disease is a group of eye problems that can affect people with diabetes, and even starts during the prediabetes stage. These conditions include diabetic retinopathy, diabetic macular edema, cataracts, and glaucoma.

Over time, diabetes can cause damage to your eyes that can lead to poor vision or even blindness. But you can take steps to prevent diabetic eye disease, or keep it from getting worse, by taking care of your diabetes. We will cover that in the second half of this course in greater detail.

Your eyes may seem fine, but having a full, dilated eye exam is the only way to know for sure if you have eye damage from diabetes and its progression.

Often, there are no warning signs of diabetic eye disease or vision loss when damage first develops. A full, dilated eye exam helps to find and treat eye problems early—often before much vision loss can occur.

Diabetes affects your eyes when your blood glucose, also called blood sugar, is too high.

In the short term, you are not likely to have vision loss from high blood glucose. People sometimes have blurry vision for a few days or weeks when they're changing their diabetes care plan or medicines. High glucose can change fluid levels or cause swelling in the tissues of the eyes that help the eye to focus, causing blurred vision. This type of blurry vision is temporary and goes away when the glucose level gets closer to normal.

If your blood glucose stays high over time, it can damage the tiny blood vessels in the back of your eyes. This damage can begin during prediabetes, when blood glucose is higher than normal, but not high enough for you to be diagnosed with diabetes. Damaged blood vessels may leak fluid and cause swelling. New, weak blood vessels may also begin to grow. These blood vessels can bleed into the middle part of the eye, lead to scarring, or cause dangerously high pressure inside your eye.

Most serious diabetic eye diseases begin with blood vessel problems. Remember this statement as we cover the four eye diseases that can threaten eyesight and are caused by diabetes.

Diabetic Retinopathy

The retina is the inner lining at the back of each eye. The retina senses light and turns it into signals that your brain decodes, so you can see the world around you. Damaged blood vessels can harm the retina, causing a disease called diabetic retinopathy.

In early diabetic retinopathy, blood vessels can weaken, bulge, or leak into the retina. This stage is called nonproliferative diabetic retinopathy.

If the disease gets worse, some blood vessels close off, which causes new blood vessels to grow, or proliferate, on the surface of the retina. This stage is called proliferative diabetic retinopathy. These abnormal new blood vessels can lead to serious vision problems.
Here is an example of how advanced Diabetic Retinopathy could look to the patient:

Normal vision of two boys playing

This photo shows how retinopathy might affect vision. Dark spots hang over a view of two boys with rubber balls. The spots block their faces. Photo courtesy of the National Eye Institute

About one in three people with diabetes who are older than age 40 already have some signs of diabetic retinopathy. Diabetic retinopathy is the most common cause of vision loss in people with diabetes. Each person's outlook for the future, however, depends in large part on regular care. Finding and treating diabetic retinopathy early can reduce the risk of blindness by 95 percent.

Diabetic Macular Edema

The part of the retina that we need for reading, driving, and seeing faces is called the macula. Diabetes can lead to swelling in the macula, which is called diabetic macular edema. Over time, this disease can destroy the sharp vision in this part of the eye, leading to partial vision loss or blindness. Macular edema usually develops in people who already have other signs of diabetic retinopathy.

Glaucoma

Glaucoma is a group of eye diseases that can damage the optic nerve—the bundle of nerves that connects the eye to the brain. Diabetes doubles the chances of having glaucoma, which can lead to vision loss and blindness if not treated early.

Symptoms depend on which type of glaucoma has been diagnosed.

This photo shows how glaucoma affects vision. Shadows darken all sides of a view of two boys. Only the center is bright enough to see clearly. Photo courtesy of the National Eye Institute

People with glaucoma slowly lose side vision.

Cataracts

The lenses within the eyes are clear structures that help provide sharp vision—but they tend to become cloudy as we age. People with diabetes are more likely to develop cloudy lenses, called cataracts. People with diabetes can develop cataracts at an earlier age than people without diabetes. Researchers think that high glucose levels cause deposits to build up in the lenses of your eyes.

A blurry photo shows two boys with rubber balls. The photo shows how cataracts, affect vision. Photo courtesy of the National Eye Institute

Cloudy vision and faded colors are symptoms of cataracts.

A diabetic's chances of developing glaucoma or cataracts are about twice that of someone without diabetes.

Anyone with diabetes can develop diabetic eye disease. Your risk is greater with:

- high blood glucose that is not treated
- high blood pressure that is not treated

High blood cholesterol and smoking may also raise your risk for diabetic eye disease.

Some groups are affected more than others. African Americans, American Indians and Alaska Natives, Hispanics/Latinos, Pacific Islanders, and older adults are at greater risk of losing vision or going blind from diabetes.

Duty to warn and Communicate

We need to remind the patient to call the doctor right away if they notice sudden changes to vision, including flashes of light or many more spots (floaters) than usual. (also if it looks like a

curtain is pulled over their eyes). These changes in eye sight can be symptoms of a detached retina which is a medical emergency.

As an Optician for almost 50 years, I feel It is our duty as Opticians to communicate this to patients, but doubly so to diabetic patients. Remember the patient is usually quite uninformed on this subject and so often the Doctor doesn't have time to talk about this in much detail and can generalize in some very confusing medical terms that the patient does not have a clue about. Trust me when I say this, the patient will love you for giving this communication to them as to what to look for and possibly save their eye sight down the road. For one example, I have had many a patient that did not know what or how dangerous the "lightning flashes" could be until it was too late, yet they had been to an Ophthalmologist every year for at least 15 years before this happened. And just to clarify, this patient was new to me and had been going to an Ophthalmologist and buying their glasses at a rushed atmosphere in a "big box" store. It seems as though nobody informed them of the hazards of this issue even though I found evidence of vitreous detachment in previous exams.

In our duty to warn Let's also review the protocol recommended by Optometrist and Ophthalmologist for Eye exam guidelines for diabetes:

Type 1: Yearly eye exams should start within 5 years of diagnosis.
Type 2: Yearly eye exams should start right after diagnosis.
Pregnancy: Women with type 1 and type 2 diabetes need an eye exam before pregnancy or within the first 3 months.
Most people with diabetes should see an eye care professional once a year for a complete eye exam.

And now we are running into a new issue in our field of Opticianry that I mentioned above, one that involves the "fast" eye exam, When a diabetic patient needs more time to diagnose these issues, we see some doctors doing just a refraction rather than a full eye exam. It should not just be about the money, but how we can help these patients attain better treatment and health, And remember not to overstep your boundaries as an Optician, we cannot prescribe, so be careful how you help them. You can get around some of those issues if you work closely with an understanding Doctor during the treatment. Sometimes you can put a thought in the patient's head to do their due diligence in research on the issue and learn what they need to try for each individual case. After all, if the patient pays attention to their own body and assesses what their personal needs are , the results can be astonishing with self-discipline.

The sooner we can work to manage the patient with diabetes and other health conditions, the better. We may be able to prevent blindness by communicating the next section on helping the patient help themselves with diet, nutrition, exercise and lifestyle changes. So here we go!
It's time to outline a program to reverse this condition. Remember what I said earlier, type 2 may be reversible, and in the vast majority of cases does not require any form of medication. (if

it is caught early enough) I did not go into detail concerning the medication and treatment we currently use in the US for diabetes. As most of us know the most common way is pills and insulin. But lets look at this for just a moment.

New Warning:
Insulin Can Rapidly Produce Type 1 Diabetes in Type 2 Diabetics!

Please understand that medications and supplements are not the answer for type 2 diabetes. I am sure you have seen the ads on TV that tout the use of some drug and then give you a myriad of side effects that could even be death. Like most you see on TV, Diabetes drugs fail to address the underlying problem, and many, like Avandia or Metformin, can have dangerous side effects. Avandia is linked to 43 percent increased risk of heart attack and 64 percent higher risk of cardiovascular death, compared with other treatments. Metformin can cause lactic acidosis, diarrhea, nausea and vomiting. The risk of lactic acidosis increases with renal or hepatic impairment. Instead of these drugs, most people can control their type 2 diabetes by restoring their insulin and leptin sensitivities. This is done by eliminating grains (carbohydrates that turn into sugar) and sugars—especially fructose—from your diet, getting plenty of healthy fats, exercising, and sleeping well. Further details on this will be provided below, in the treatment section.

Important Note! Recent research published in the Journal of Clinical Endocrinology & Metabolism confirms what Dr. Ron Rosedale has stated for the last two decades, which is that insulin treatment can provoke otherwise reversible type 2 diabetes to progress into type 1 insulin deficient and therefore insulin-dependent diabetes. The study found that giving genetically engineered recombinant insulin to type 2 diabetics with certain genetic susceptibility can trigger their bodies to produce antibodies that destroy their insulin producing cells (pancreatic islet cells). You may not realize that all human insulin, the type typically used, is GMO or genetically modified which might be responsible for this autoimmune reaction.

Basically, it triggers an autoimmune disease response, producing a condition in which you have both type 1 and type 2 diabetes simultaneously. The average time of type 1 diabetes onset was 7.7 months. One study participant developed type 1 diabetes in just over one month! According to the authors, acute deterioration of blood glucose control after administering insulin is a warning sign of this problematic side effect. According to this study, the genes predisposing you to this autoimmune-type response to insulin are:

Type 1 diabetes high risk HLA class II (IDDM1), thought to play a role in about half of all type 1 diabetes cases

VNTR genotype (IDDM2), which is believed to predispose you to type 2 diabetes

This is yet another way conventional diabetic treatment pushes diabetics into premature death... Research published last year revealed that treating type 2 diabetes with insulin more than doubled patients' risk of all-cause mortality. It also leads to:

Twice as many myocardial infarctions	**1.4 time more strokes**	**2.1 time more neuropathy**	**1.4 times more cancer**
1.7 time more major adverse cardiac events	**3.5 times more renal complications**	**1.2 times more eye complications**	**2.2 times more deaths**

How to Prevent and Treat Insulin/Leptin resistance and Type 2 diabetes

Here I want to take a look at the most advanced research on preventing or reversing type 2 diabetes.

This section will also show you how overweight and obesity is caused by this resistance and therefore is the main cause of diabetes and other health issue. Remember, 75% of the population in the US is overweight or obese. So they are predicting a huge surge in pre diabetes and diabetes in the most of these people, so does this mean the 25% with this condition now, will become 50% over the next few years?

Newest evidence in research since 2014- Leptin—An Oft-Ignored KEY Player in Type 2 Diabetes Development

What in the world, you may ask is Leptin? While much conventional advice centers around insulin, Leptin is another hormone that plays an integral role in the development of type 2 diabetes. Leptin is produced in your fat and other cells, and one of its primary roles is regulating your appetite and body weight. Leptin tells your brain when to eat, how much to eat, and most importantly, when to stop eating. Leptin also instructs your brain as to what to do with the available energy.

Now remember, when your blood sugar becomes elevated, insulin is released to direct the extra energy into storage—the majority of which is stored as fat, and Leptin is produced in these fat cells. The more fat you have, the more leptin is produced. Furthermore, as the sugar gets metabolized in your fat cells, the fat releases further surges in leptin. This is why typically the research has talked about insulin and Leptin resistance, as they work in tandem. Moreover,

Leptin is largely responsible for the accuracy of insulin signaling and whether or not you become insulin-resistant. If you're insulin resistant, you're more than likely leptin resistant as well, especially if you're overweight or obese.

Why?

Because when you develop leptin resistance, your brain can no longer hear leptin's signals, resulting in chronic hunger, overeating, inability to properly burn fat and, typically, obesity. Insulin resistance, and ultimately type 2 diabetes, follow suit. Just as with insulin, the only known way to reestablish proper Leptin signaling is through proper diet. High consumption of carbohydrates, especially fructose, are again the prime culprit and the root cause of Leptin resistance. Lack of exercise and abnormal gut flora (Probiotics) also contribute and/or exacerbate insulin and Leptin resistance. Leptin's importance in blood glucose control and diabetes is powerfully illustrated by recent studies that show its ability, even in low doses, to lower blood glucose in both type 1 and 2 diabetics, and this is an exciting new potential treatment.

Honest reflection, a strong will and self discipline…

The following nutrition and lifestyle modifications should be the foundation of your diabetes prevention and treatment plan. Also, make sure to monitor your FASTING insulin level. This is every bit as important as monitoring your fasting blood sugar. You'll want your fasting insulin level to be between 2 and 4. The higher your level, the greater your insulin resistance and the more aggressive you need to be in your treatment plan, especially when it comes to altering your diet.

• Swap out processed foods, all forms of sugar—particularly fructose—as well as all or most grains, for whole, fresh food. A primary reason for the failure of conventional diabetes treatment over the last 50 years has to do with seriously flawed dietary recommendations. Fructose, grains, and other sugar forming starchy carbohydrates are largely responsible for your body's adverse insulin reactions, and all sugars and grains—even "healthful" grains such as whole, organic ones—need to be drastically reduced.

If you're insulin/Leptin resistant, have diabetes, high blood pressure, heart disease, or are overweight, you'd be wise to limit your total fructose intake to 15 grams per day until your insulin/Leptin resistance has resolved. This includes about 80 percent of Americans. For all others, according to this research, it is recommended to limit your daily fructose consumption to 25 grams or less, to maintain optimal health.

The easiest way to accomplish this is by swapping processed foods for whole, ideally organic foods. This means cooking from scratch with fresh ingredients. Processed foods are the main source of all the primary culprits, including high fructose corn syrup and other sugars, processed grains, Trans fats, artificial sweeteners, and other synthetic additives that may aggravate metabolic dysfunction.

Besides fructose, Trans fat (NOT saturated fat) increases your risk for diabetes by interfering with your insulin receptors. Healthy saturated fats do not do this. Since you're cutting out a lot of energy (carbs) from your diet when you reduce sugars and grains, you need to replace them with something. The ideal replacement is a combination of:

- Low-to-moderate amount of high-quality protein. Substantial amounts of protein can be found in meat, fish, eggs, dairy products, legumes, and nuts. When selecting animal-based protein, be sure to opt for organically raised, grass-fed or pastured meats, eggs, and dairy, to avoid potential health complications caused by genetically engineered animal feed and pesticides.

Dr Joseph Mercola believes most Americans eat far too much protein, so be mindful of the amount! He believes it is the rare person who really needs more than one-half gram of protein per pound of lean body mass. Those that are aggressively exercising or competing and pregnant women should have about 25 percent more, but most people rarely need more than 40-70 grams of protein a day. The current per capita annual consumption of meat is 222 lbs. That means the average America is eating over 9.7 oz of meat each day along with protein from other sources. Considering that Vegans/Vegetarians make up about 9% of the USA population and 46% of Americans eat Vegan/Vegetarian at least 1-2 days per week, then that average of 9.7 oz becomes more like 14-16 oz a day for at least 25% of the population. If we go by the science of eating less meat we should only have maybe 3-4 oz of meat per day, (68-88 lbs of meat per capita vs 222-250 lbs per capita) Also some of your protein should be coming from beans, vegetables, eggs, seeds and nuts.

To determine your lean body mass, find out your percent body fat and subtract from 100. This means that if you have 20 percent body fat, you have 80 percent lean body mass. Just multiply that by your current weight to get your lean body mass in pounds or kilos. To determine whether you're getting too much protein, simply calculate your lean body mass as described above, then write down everything you're eating for a few days, and calculate the amount of daily protein from all sources.

Again, you're aiming for one-half gram of protein per pound of lean body mass, which would place most people in the range of 40 to 70 grams of protein per day. If you're currently averaging a lot more than that, adjust downward accordingly.

You can get a good idea of protein content in your food from the following chart below or simply do a web search for the food you want to know and you will quickly find the grams of protein in the food.

Red meat, pork, poultry and seafood average 6-9 grams of protein per ounce. An ideal amount for most people would be a 3 ounce serving of meat or seafood (not 9 or 12 ounce steaks!), which will provide about 18-27 grams of protein	Eggs contain about 6-8 grams of protein per egg. So an omelet made from two eggs would give you about 12-16 grams of protein. If you add cheese, you need to calculate that protein in as well (check the label of your cheese)
Seeds and nuts contain on average 4-8 grams of protein per quarter cup	Cooked beans average about 7-8 grams per half cup
Cooked grains average 5-7 grams per cup	Most vegetables contain about 1-2 grams of protein per ounce

- As much high-quality healthy fat as you want (saturated and monounsaturated). For optimal health, most people need upwards of 50-85 percent of their daily calories in the form of healthy fats. Good sources include coconut and coconut oil, avocados, butter, nuts, and high quality animal fats. (Remember, fat is high in calories while being small in terms of volume. So when you look at your plate, the largest portion would be vegetables.)

- As many non-starchy vegetables as you want

- Exercise regularly and intensely. Studies have shown that exercise, even without weight loss, increases insulin sensitivity. High intensity interval training (HIIT), which should be a part of anybody's fitness program, has been shown to improve insulin sensitivity by as much as 24 percent in just four weeks. (check with your doctor before starting such an intense exercise program.)

- Improve your omega-3 to omega-6 ratio. Today's Western diet has far too many processed and damaged omega-6 fats, and has far too few omega-3 fats. The main sources of omega-6 fats are corn, soy, canola, safflower, peanut, and sunflower oil (the first two of which are typically genetically engineered as well, which further complicates matters). Our bodies evolved for an optimal 1:1 ratio of omega-6 to omega-3. However, our ratio has deteriorated to between 20:1 and 50:1 in favor of omega-6. This lopsided ratio has seriously adverse health consequences.

To remedy this, reduce your consumption of vegetable oils (this means not cooking with them, and avoiding processed foods), and increase your intake of animal-based omega-3, such as krill oil. Vegetable-based omega-3 is also found in flaxseed oil and walnut oil, and it's good to include these in your diet as well. Just know they cannot take the place of animal-based omega-3s. (hence the well known issues with Vegan diets more so than vegetarian diets)

• Maintain optimal vitamin D levels year-round. New evidence strongly supports the notion that vitamin D is highly beneficial not only for type 1 diabetes (before the pancreas islet dies off), but also in type 2 diabetes. The ideal way to optimize your vitamin D level is by getting regular sun exposure. As a last resort, consider oral supplementation with regular vitamin D monitoring, to confirm that you are taking enough vitamin D to get your blood levels into the therapeutic range of 50-70 ng/ml. Also please note that if you take supplemental vitamin D, you create an increased demand for vitamin K2.

• Get adequate high-quality sleep every night. Insufficient sleep appears to raise stress and blood sugar, encouraging insulin and leptin resistance and weight gain. In one 10-year long study of 70,000 diabetes-free women, researchers found that women who slept less than five hours or more than nine hours each night were 34 percent more likely to develop diabetes symptoms than women who slept seven to eight hours each night. If you are having problems with your sleep there are many ways of improving this, but that is a whole other course!

• Maintain a healthy body weight. If you incorporate the diet and lifestyle changes suggested above you will greatly improve your insulin and Leptin sensitivity, and a healthy body weight will follow in time. Determining your ideal body weight depends on a variety of factors, including frame size, age, general activity level, and genetics. As a general guideline, you might find a hip-to-waist size index chart helpful. This is far better than BMI for evaluating whether or not you may have a weight problem. BMI fails to factor in both how muscular you are, and your intra-abdominal fat mass (the dangerous visceral fat that accumulates around your inner organs), which is a potent indicator of Leptin sensitivity and associated health problems.

• Incorporate intermittent fasting. If you have carefully followed the diet and exercise guidelines and still aren't making sufficient progress with your weight or overall health, Dr Mercola strongly recommends incorporating intermittent fasting. This effectively mimics the eating habits of our ancestors, who did not have access to grocery stores or food around the clock. They would cycle through periods of feast and famine, and modern research shows this cycling produces a number of biochemical benefits, including improved insulin/Leptin sensitivity, lowered triglycerides and other biomarkers for health, and weight loss. I have found the book written by Jason Fung MD, “The Complete Guide to Fasting” to be quite an eye opener.

Intermittent fasting is by far the most effective way I know of to shed unwanted fat and eliminate your sugar cravings. Intermittent fasting has also been identified as a potent ally for

the prevention and perhaps even treatment of dementia. Ketones are released as a byproduct of burning fat, and ketones (not glucose) are actually the preferred fuel for your brain. Keep up your intermittent fasting schedule until your insulin/Leptin resistance improves (or your weight, blood pressure, cholesterol ratios, or diabetes normalizes). After that, you only need to do it "as needed" to maintain your healthy state. A good percentage of people have bought into the concept of eating 6 meals a day and think they get dizzy if they do not eat that many times during the day. Yes, at first you may need to work up the intermittent fasting times. I personally find 16-21 hours very doable. But at first I started no late night eating. Also we should not eat within 3 hours of going to bed, as digestion interferes with sleep repair or the circadian rhythm of the body organ repair schedule at night. (Circadian rhythm, something else for you to websearch!) So I first adapted my body to stop eating 3-4 hours before bed, then after that was working very well, I started adding 30 minutes at a time the next morning to work up to the 16 or more hours of fasting. You will be surprised how fast the body adapts and no dizzy spells. Again you should check with your doctor to understand any complications you may have that would interfere with this. Most can adapt.

• Optimize your gut health. Your gut is a living ecosystem, full of both good bacteria and bad. Multiple studies have shown that obese people have different intestinal bacteria than lean people. The more good bacteria you have, the stronger your immune system will be and the better your body will function overall. And taking a probiotic as a supplement will only work temporarily as your gut needs much more healing before the probiotics re-colonize your gut versus a pass through of pills. Fortunately, optimizing your gut flora is relatively easy. You can re-seed your body with good bacteria by regularly eating fermented foods (like natto, sauerkraut, raw organic cheese, miso, and cultured vegetables). The latest research on the gut has shown that it is connected to the brain for communications and helps the whole body perform better, including the eyes!

The good news? You CAN Prevent and reverse Type 2 Diabetes

You don't have to be a part of the diabetes epidemic that is taking place before your eyes; you merely need to make some lifestyle changes and be mindful about your habits. The changes, detailed above, will prevent you from heading down the diabetes path, and can be the U-turn you've been looking for if you're already insulin resistant or diabetic. None of these strategies are expensive or overly time-consuming. However, they do require a measure of honest reflection and discipline. Plus if you share this information to your friends and patients, you may be saving somebody’s vision!

Now that you have an understanding of what diabetes really is and how it develops, you can steer clear of behavior patterns that harm your health, and incorporate those that will enhance

your quality of life. Again, type 2 diabetes involves loss of insulin and Leptin sensitivity, which is easily preventable, and nearly 100 percent reversible without drugs, by addressing your diet and other lifestyle habits, such as exercise, sleep, and intermittent fasting. I suggest taking a lifestyle inventory to see where you might have room for improvement.

For example:

- Review your eating patterns. How much sugar and sugar-forming carbohydrates are you eating daily? Is corn syrup a primary staple of your diet, hidden in the processed foods you buy on a regular basis? Are you spending your time in the middle of the grocery store, or around the periphery? (Most processed foods come from the middle aisles.)

- Are you an "emotional eater"? Do you tend to overindulge in comfort foods when you are feeling sad or angry? If so you have emotional issues to resolve first.

- Evaluate your activity level. Are you getting enough exercise each week?
- Are you getting enough sunlight? Have you measured your vitamin D levels lately? Unless you are deeply tanned, that is the only way to know your level. Do you need to consider a vitamin D supplement?

- Are you getting enough magnesium in your diet? Early signs of magnesium deficiency include loss of appetite, headache, nausea, fatigue, and weakness. An ongoing magnesium deficiency can lead to more serious symptoms, including muscle spasms and abnormal heart rhythms.

What patterns are you inadvertently passing along to your children? What example are you setting for your kids, in terms of nutrition and exercise? Are they getting the message that health is a priority? Getting healthy can and should be a family activity! When everyone is involved, you can support each other and give kudos for positive strides, making it more fun for everyone. The payoffs to your health will be great, and you will be passing along good lifestyle habits to your children, which will serve them for years to come.

And all of this may seem overwhelming for many, but a bit of perseverance will make this a healthy lifestyle change and it will become an easy routine once learned. Remember, the health pyramid given us in school since the early 1960s that was purported to us to be a way of a healthy life has been proven wrong! I remember my grandparents trying to eat fewer eggs, no fat from butter, (the pyramid recommended Margarine, omega 6s), more grains and less meat. We were taught that all saturated fat was bad, yet today the experts on nutrition are reversing all of what was taught in school those years!

Herbal supplements and how they may help Diabetes

This is a very interesting part of the control of Pre-diabetes and even type 2 diabetes because there is so much controversy over herbs vs pharmaceuticals. So I will only bring up a couple of the herbs that have extensive research proving their worth.

Berberine-coptis chinensis (Huanglian)

First lets review the most useful of all supplements/herbs, Berberine. What is that you may ask?

Berberine is a compound originally extracted from the Chinese herb – coptis chinensis (Huanglian). But according to Dr. Morstein, it can be found in many different botanicals: Barberry, Oregon Grape, Goldenseal, Chinese goldthread, California poppy, and others.

Dr. Ralph Esposito and Dr. Mona Morstein

Even though berberine may be new to you, it has been around for a long time – being used in folk medicine, along with traditional Chinese, Indian and Middle-Eastern medicine for over 400 years.
So, not surprisingly, this yellow-colored, alkaloid compound is now being studied by avid scientists for its numerous health benefits, which include:

lowering blood glucose
improving metabolism
assisting with weight loss
boosting heart health
cutting inflammation-(the main culprit leading to diabetes!)

And of course, the most interesting benefit to our discussion here is how it can improve type 2 diabetes or prediabetes, and berberine's ability to help improve blood glucose control.

Lets look at the research closely here.

Berberine for Better Blood Glucose Control

Quite amazingly, berberine has been shown to help control blood sugar levels as effectively as Metformin – (I talked about this and other pharmaceuticals earlier in the course and gave you the side effects of them, and why they can be as dangerous as helpful) Whereas Berberine does not have any known side effects other than a possible slight digestive issue with only a few people and if you lower the dose a bit, you may be able to eliminate it.

Researchers compared the glucose-lowering effects of berberine and Metformin in newly diagnosed adults with type 2 diabetes, over the course of 13 weeks.

The randomized groups were given either 500 mg of berberine per day, 3 times per day, or 500 mg Metformin, 3 times per day after meals. If people experienced any gastrointestinal side effects from the berberine, their dosage was reduced to 300 mg, 3 times per day.

The results at the conclusion of the study showed that the glucose-lowering effect of berberine was highly similar to that of Metformin. And in fact, outperforming it for A1c reduction!

Metformin

A1c reduced by 1.43%
Postprandial (after meal) blood glucose levels reduced by 138.1 mg/dL (7.67 mmol/l)
Fasting blood glucose reduced by 50.4 mg/dL (2.8 mmol/l)

Berberine

A1c reduced by 1.99%
Postprandial (after meal) blood glucose levels reduced by 158 mg/dL (8.78 mmol/l)
Fasting blood glucose reduced by 68 mg/dL (3.78 mmol/l)

“This study of berberine against Metformin at equal doses was very impressive, with berberine lowering A1c by 2%, which is higher than any conventional oral hypoglycemics have been shown to lower A1c in the same time,” says Dr. Morstein.

The same study also set a secondary study with combination therapy, adding 500 mg of berberine alongside Metformin for an additional 5 weeks. Fasting blood glucose showed a dramatic reduction and A1c reduced by 0.8%.

Results from a review of clinical trials also demonstrate that berberine stands up against diabetic medications:

Berberine vs Metformin – 500 mg per day, 3 times per day berberine vs 0.75 g metformin – no difference in fasting blood glucose and A1c – meaning they performed the same.

Berberine vs rosiglitazone (Avandia) – Two clinical trials demonstrated that berberine performs better than the medication rosiglitazone for lowering fasting blood glucose, with no difference between the two for A1c reductions.

Berberine vs glipizide – no significant difference in the fasting blood glucose outcomes for groups.

What about when berberine is taken in conjunction with other medications? Well, let's take a closer look…

Berberine + Metformin vs Metformin(by itself) – 5 trials have demonstrated combination therapy improves fasting blood glucose and A1c more than using Metformin alone.

Berberine + glipizide vs glipizide – one trial has shown that combo therapy may be more beneficial for lowering postprandial blood glucose.

How Does Berberine Work?

We have already learned about insulin resistance earlier in this discussion, so lets apply what we learned above to Berberine.

Insulin is the hormone produced by your pancreas that is needed to help glucose (sugar) move out of your bloodstream and into the cells (such as muscle and liver cells). On the outside of cells lies ‘insulin receptors' and under normal circumstances, insulin acts as the key to unlock the cells so that clearing of the bloodstream can occur.

If you have insulin resistance, then the door is not unlocked

Another important thing to recognize is it's not just the pancreas and insulin involved here. Your liver plays a critical role in insulin resistance, along with energy metabolism as well.

Now that you have those concepts in mind, let's move on to how berberine works…

Dr. Morstein explains that berberine influences the AMPK pathway (adenosine monophosphase-activated protein kinase). "The AMPK is a cellular enzyme that is a regulator for how energy is produced and used in body cells," she explains. "It induces numerous events in the cells involved in helping the body maintain its energy needs. If a cell is low in energy the AMPK signals the production of more energy. And it also regulates activities such as lipid and glucose production."

"When insulin resistance is occurring the AMPK regulated pathways are shut off, triggering the development of hyperglycemia, increased cholesterol and triglycerides, and of course, diabetes," Dr. Morstein continues. "If the AMPK is once again activated, as it can be with the addition of berberine, those pathways can be corrected and therefore, initiate weight loss, energy burning and reduced glucose and lipids."

"In Western botanical medicine, berberine is considered an "alterative," that is, an herb that helps support the functioning and health of the liver, and the production and secretion of bile. The liver is a key organ for insulin resistance, and most obese patients have fatty liver. Therefore, supporting liver health and functioning is an added bonus to using berberine," adds Dr. Morstein.

Indeed, research on liver cells shows that berberine increases the expression of insulin receptors by as much as 40%, making them more sensitive to insulin so they can unlock those cell doors.

Similarly, berberine also improves insulin sensitivity in muscle cells, increasing the activity of glucose transporters, and therefore improving overall glucose metabolism.

Additionally, berberine alters glucose metabolism by stimulating glycolysis – a pathway of nutrient metabolism that can become disrupted in diabetes and prediabetes. Glycolysis is the pathway that assists with utilizing and storing glucose in the body.

Another function of berberine is it suppresses gluconeogenesis, the production of glucose in the liver. If you have high morning blood sugar levels, this is often the result of gluconeogenesis – your liver producing glucose, along with your body's lack of ability to hormonally counteract/control these effects.

Other potential mechanisms of berberine include:

- Influencing intricate cellular transcription factors
- Improving pancreatic function and stimulating insulin secretion
- Increasing glucose uptake and decreasing glucose absorption
- Reducing inflammation (can also be useful for inflammation diseases such as arthritis & cataracts) Diabetes is an inflammation disease!

In any case, the results of studies clearly show that berberine could be a beneficial inclusion to your diabetes or prediabetes treatment plan, either in solo or as a combo therapy alongside the medications you already take.

Yes, that's right. You can even take it alongside medications you already take, as the studies above showed. And these effects are being seen in real life scenarios.

"Oftentimes my diabetic patients are already taking prescription medications for their diabetes," says Dr. Esposito. "I have seen berberine work exceptionally well alone, and I often begin first with berberine capsules and nutritional therapy. If those are not providing benefit, I find berberine to work well with Metformin as well. Generally berberine is safe and effective with other diabetic drugs," he says.

But once again, the patient should talk to their doctor about using it before starting..

There are several other herbs/supplements that show a promise to help pre-diabetes and diabetes.

Fenugreek

Fenugreek is a seed that may help lower blood sugar levels.

The seeds contain fibers and chemicals that help to slow down the digestion of carbohydrates and sugar.

There is also some evidence that the seeds may help delay or prevent the onset of type 2 diabetes.

Findings of a 3-year investigation published in 2015 noted that people with prediabetes were less likely to receive a diagnosis of type 2 diabetes while taking powdered fenugreek seed.

The researchers concluded that taking the seed led to:

increased levels of insulin in the body, leading to a reduction in blood sugar
lower cholesterol levels

The study involved 66 people with diabetes who took 5 grams (g) of the seed preparation twice a day before meals, and 74 controls, who did not take it.

A person can:

include fenugreek as a herb in certain dishes
add it to warm water
grind into a powder
take it as a supplement in capsule form

Gymnema

Gymnema sylvestre is a herb that comes from India. Its name means “sugar destroyer.”

A 2013 review noted that people with both type 1 and type 2 diabetes who took gymnema showed signs of improvement.

In people with type 1 diabetes who took the leaf extract for 18 months, fasting blood sugar levels fell significantly, compared with a group who received only insulin.

Other tests using gymnema found that people with type 2 diabetes responded well to both the leaf and its extract over various periods.
Some people experienced:
lower blood sugar levels
higher insulin levels
Using either the ground leaf or leaf extract may be beneficial. But once again, the patient should talk to their doctor about using it before starting.

Vitamins

We cannot leave out vitamins and how they may help diabetics. A very important and little known dietary phenomena is that diabetes is a nutritional wasting disease – when blood glucose (sugar) levels are high, they act as a diuretic. This causes excessive urination, which

washes out loads of nutrients including antioxidants, vitamins and minerals such as magnesium and zinc.

The second reason is glycation, a process in which glucose molecules react with proteins in the body – this damages the protein turning them into nonfunctional structures called advanced glycation end products (AGEs). Unfortunately, although glycation is a key-feature of diabetes-related complications such as blindness, heart attack and nerve damage, it does not figure in conventional treatment for diabetes. You've probably heard of glycated hemoglobin (HbA1c), a well known AGE among diabetics. Well, HbA1c is formed when glucose molecules in the blood attach to hemoglobin – measuring your HbA1c will give you a picture of the extent to which your hemoglobin is exposed to glucose (that is, how controlled your blood glucose levels are.)

The third reason is that diabetes causes a lot of oxidative stress – elevated blood glucose levels and glycation produce free radicals that further damage proteins in your body while reducing levels of nitric oxide. Since the arteries are kept relaxed and wide open by nitric oxide, high levels of free radicals adversely affect arteries throughout the body. This can pave the way for numerous complications and is the reason why individuals suffering from diabetes face higher risks of atherosclerosis (the hardening of arteries), heart disease and heart attacks.

I will not go into the details of which vitamins for this study of diabetes, but you can find more detail about which ones in my references under Health Wholeness.

So, why won't strict blood glucose control solve this issue?

Although maintaining optimal blood glucose levels will help reduce urinary losses of micronutrients and decrease the stress induced by diabetes, doing so does not eliminate these issues. You see, another complication of diabetes is that the individuals often face regular periods of high blood glucose levels even if their overall blood glucose control is good. Unfortunately, most conventional physicians miss that point.

A diet naturally rich in vitamins and minerals can help reduce glycation and oxidative stress while toning down inflammation. In fact, a large human trial showed that for each 1 percent reduction in HbA1c, there was:

- A 37% reduction in microvascular complications which affect small blood vessels in the eyes, nerves and kidneys. (*remember I told you in the introduction to watch for this information about blood vessels? Here it is again!)*
- A 21% decrease in risk for any complication of diabetes.
- A 21% decline in deaths linked to diabetes.
- A 14% reduction in heart attack.

So again we have shown where inflammation is a key part of the Diabetes and this causes the eye to stress and develop the 4 eye diseases we mentioned at the beginning of this. So see how it is coming together?

Conclusion

In summary, I described the process of Diabetes and how it contributes to 4 eye diseases. I have shown you that simply swapping processed foods for whole organic foods lower in sugar and sugar-forming carbohydrates combined with a few minutes of daily exercise will quickly put you on the road to reversing this condition. In fact I have seen many cases of people do this in 3-6 weeks for pre-diabetes. Of course Diabetes is a bit harder to reverse, but very possible. I realize that some of the information in this course is beyond what some of you have considered in your diet, but like I started the course with, I am a living example of what this type of diet can do for you. I "cured" my diabetes back in 1975 and have continued on this healing diet since. (Frankly, I have gotten even more advanced with this diet and more compliant.) It took about 10 months for my diabetes to heal, So the best take away for this course is in one word….Perseverance!

As Jack Lalanne would say: "If man made it, don't eat it"

And remember, a diabetic did not get the diabetes overnight, as it took possibly years of bad diet and sitting on the couch watching TV (lack of exercise) Lets not be impatient and work this lifestyle through our best efforts. There is no quick fix with a pill as most Americans tend to think.

The sooner we start, the better results, because the more advanced, the more damage and your only hope then is to 'control' the progression of diabetes and you may need medication at that point of advancement of the diabetes. But again, in the earlier stages of pre-diabetes and even early on for type 2 diabetes, these cases can be reversed, at least in Type 2 and maybe in a few years we will see some reversal of type 1. (According to the promising research going on.) The medication will seemingly "fix" the diabetes, but to change diet, exercise and supplementation will heal the body most of the time and could at least get better if you have been on medication too long to change up. Another consideration in all of this, is find a physician who will understand your concerns, as just like anything else, not everyone is on the same page as you are, and neither are all doctors! Lets try to stop as much blindness as we possibly can. And the best way is to stop eating sugar! (I know I ask a lot of you "sugarholics"!)

"I havent had dessert since 1929" Jack Lalanne 1914-2011 (96)

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Berberine: https://diabetesmealplans.com/10647/

Health wholeness (vitamins) https://healthwholeness.com/diabetes/vitamins-for-diabetes/

Sepalika (vitamins) https://www.sepalika.com/type-2-diabetes/vitamins-for-diabetics/

Regenerative Farming:
https://www.youtube.com/watch?v=3iknWWKZOUs&feature=share&fbclid=IwAR3WLkTSb_jiuwoDy57ENIrdB2Kvp-22nuhlUmKsgy4NbhPjbuu02rLKeAk

25 Test Questions for:
Can Nutrition Reverse Diabetes & its Causation of Eye Diseases?

1. If we are what we eat which of the following should we choose?:
    a. A highly processed, edible food-like substance comprised of 20+ chemicals
    b. An Organic Vegetable
    c. McDonald's Cheese burger
    d. All of the above

2. Type 1 refers to:
    a. Insulin dependent diabetes
    b. An autoimmune disease
    c. Usually develops before 20 years old
    d. All of the above

3. Type 2 refers to:
    a. Insulin dependent diabetes
    b. Non-Insulin dependent diabetes
    c. The newest model of a Tesla automobile
    d. None of the above

4. There is now a Type 3 diabetic condition:
    a. True
    b. False
    c. I have no clue

5. Which type of Diabetes is being studied for a cure using gene therapy?
    a. Type 1
    b. Type 2
    c. Type 3
6. Which country has proposed that Glaucoma may be a result of diabetes Type 3
    a. USA
    b. Great Briton
    c. Switzerland
    d. India
7. How many people in the USA by percentage, does pre-diabetes or diabetes affect?
    a. 33%
    b. 25%
    c. 40%
    d. 50%
8. In the early stages of this eye disease blood vessels can weaken, bulge or leak.
    a. Diabetic Retinopathy
    b. Diabetic macular edema
    c. Glaucoma
    d. Cataracts
9. In this eye disease there is swelling….
    a. Diabetic Retinopathy
    b. Diabetic macular edema
    c. Glaucoma
    d. Cataracts

10. In this eye disease the Optic Nerve is damaged
    a. Diabetic Retinopathy
    b. Diabetic macular edema
    c. Glaucoma
    d. Cataracts
11. In this eye disease the Patient will lose side vision
    a. Diabetic Retinopathy
    b. Diabetic macular edema
    c. Glaucoma
    d. Cataracts
12. In this eye disease glucose levels cause deposits to build up and colors fade
    a. Diabetic Retinopathy
    b. Diabetic macular edema
    c. Glaucoma
    d. Cataracts
13. How often should a person with diabetes get a full eye exam?
    a. Every year
    b. Every 2 years
    c. Every 3 years
    d. When they can no longer see clearly
14. Type 2 diabetes can rapidly produce Type 1 diabetes
    a. True
    b. False

15. Diabetics with Type 2, treated with insulin leads to how much more eye complications?

    a. 1.2

    b. 1.4

    c. 1.7

    d. 2.2

16. What hormone works with Insulin in our bodies according to the latest research?

    a. Adrenaline

    b. Cortisol

    c. Leptin

    d. Thyroxin

17. To improve health a pre-diabetic or Diabetic should restrict which of the following

    a. Grains-including whole grains

    b. Carbohydrates such as sugar and carbs that convert to sugar

    c. Trans fat and omega 6 vegetable oils

    d. None of the above

    e. All of the above

18. Protein consumption should be limited to .5 grams per pound of lean body mass

    a. True

    b. False

19. When you look at your dinner plate, the largest portion should be

    a. Fat

    b. Protein (meat)

    c. Vegetables

    d. French Fries

20. To help reverse Diabetic Eye Disease, we need this ration of Omega 3 to Omega 6
    a. 1:1
    b. 1:20
    c. 1:50
21. HIIT exercise has shown to improve this percentage in just the first 4 weeks
    a. 10%
    b. 20%
    c. 24%
22. Which Vitamin or Supplement below has been shown to improve Diabetic Eye Diseases
    a. Vitamin D
    b. Vitamin K2
    c. Magnesium
    d. All of the above
23. If everything else has failed to help lose weight and control insulin/Leptin sensitivity we should do which of the following?
    a. Intermittent fasting
    b. Cut our food down to half
    c. Take a friends advice on how they did it
24. The herb Berberine can be just as effective as Metformin for most Type 2 Diabetics
    a. True
    b. False
25. Inflammation is a key part of the Diabetes and this causes the eye to stress and develop the 4 eye diseases.
    a. True
    b. False

2020 Answer sheet (do not take a picture of this page with your smart phone!)

Can Nutrition Reverse Diabetes & its Causation of Eye Diseases?-2hr

Send this answer sheet only, do not enclose the entire printed material!

Please use a flat scanner to format in PDF, then email to: cedoinc@yahoo.com

Or: USPS Postal Mail it: CEDO INC PO BOX 46486 TAMPA, FL 33646

Name_____ Opticians License # _____

Address_____City_____State_____

Zip_____ Cell Phone_____Work Phone_____

Email:_____

This test will be graded within 2-5 days of receipt and entered into cebroker immediately!

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10/01/2020

STATE OF FLORIDA BOARD OF OPTICIANRY

NOTICE OF MEETING

TO: **CEDO, Inc.**
P.O. Box 46486
Tampa, Florida 33646

PLEASE TAKE NOTICE that CE Broker course #20-716031 – "Can Nutrition Reverse Diabetes & its Causation of Eye Disease?", is on the October 23, 2020 agenda for review by the Board of Opticianry. The meeting is scheduled to begin at 9:00 A.M., EST via teleconference call. The dial-in information is:

Dial-in #: 1 (888) 585-9008 Participation Code: 123-475-828 #

You are not required to appear at this meeting. However, you are encouraged to attend. It may be helpful for you to appear in the event the Board has any questions concerning this review.

This is a public meeting and participants in this public meeting should be aware that these proceedings are being recorded and that an audio file of the meeting will be posted to the board's website.

CERTIFICATE OF SERVICE

I, HEREBY CERTIFY that a true and correct copy of the above and foregoing Notice of Meeting has been sent by U.S. Mail to the above address on this October 13, 2020.

Eric Pottschmidt
Program Operations Administrator
Email: Eric.Pottschmidt@flhealth.gov
Phone: (850) 245-4292, Facsimile: (850) 413-6982
4052 Bald Cypress Way, Bin # C08
Tallahassee, Florida 32399-3258

Course Summary

CEDO INC

Course # 20 - 706479 - Anisometropia in the 21st Century

CE Committee Review Comments:

Board Review Required.

Course Addition Request	
Course Name	Anisometropia in the 21st Century
CE Broker Course Tracking #	20 - 706479
Course Description	A Primer in Dealing with Prism and Vertical Imbalance
Provider	CEDO INC
Course Type	Anytime
Delivery Method	Home Study
Provider Type	Board Approved Provider

Profession Selection + Hours	Renewal Hours	Approved Hours
Optician		
HIV/AIDS	0	
Medical Errors	0	
Technical Practice	2	
Elective	0	
Technical Practice (Contact Lens Theory and Practice)	0	
Laws and Rules of the Board (Initial Licensure or Renewal)	0	
Laws and Rules of the Board (Renewal Only, not for Initial Licensure)	0	
Laws and Rules of the Board (Apprentice Orientation)	0	
20-hour Board Certification Course (not taken to obtain Board Certification)	0	

Anisometropia in the 21st Century

A Primer in Dealing with Prism and Vertical Imbalance

Send all correspondence through:

CEDO INC PO BOX 46486 Tampa, FL 33646

By David Wood LDO (975)

Course Objectives

Upon completing this two-hour, home-study course, the optician should:

- Be more aware of the increasing number of anisometropic prescriptions and be more proficient in providing adequate solutions for the problems relating to it.
- Have a deeper understanding of terms and conditions such as amblyopia, asthenopia, diplopia, strabismus, prism, and vertical imbalance.
- Know the function and limits of slab-offs and reverse slab-offs.
- Be exposed to and competent in the process of "diagramming" to more easily determine the direction of resultant prism.
- Quickly be able to identify "problem Rxs" with regard to vertical imbalance.
- Be reminded of Prentice's Rule and consider using a more practical variation of it.
- Know when solutions other than bi-centric grinding must be implemented.
- Avoid certain language when educating your clients with regard to anisometropia.
- Be aware of outside resources to continue research on the subject of vertical imbalance.
- Have achieved a score of 75% or higher on the 50-question assessment at the end of the course.

Anisometropia in the 21st Century

A Primer in Effectively Dealing with Prism and Vertical Imbalance

I Introduction

The problems associated with vertical imbalance are on the rise. One of the most commonly performed procedures today is IOL (intraocular lens) surgery. Thousands of baby boomers become presbyopic every day. As a front-line optician, I am sure you are noticing more frequently patients who require that only one cataract be removed. Sometimes six months or a year or more goes by before the second one must be removed. Due to this ever-increasing phenomenon, an eye care professional must be ready to identify potentially "problem" prescriptions, and be adept at suggesting effective solutions for his or her patients.

Consider the following spectacle Rx:

O.D. – 2.50 – 1.75 x 120 / add +2.50
O.S. – 1.00 – 0.50 x 033 / add +2.50

If you were asked to share all of your observations about the prescription and the patient to whom it belongs, what are some of the things you might say? You would no doubt say that the patient is myopic (nearsighted); more so in the right eye than the left. The patient is also slightly astigmatic; also more so in the right eye than the left. You might observe that the axis of the cylindrical correction in the right eye is about 90-degrees different than the cylindrical correction of the left eye. You might also note that that is not uncommon. The patient is also presbyopic, and requires the same near add in both eyes. You would probably start to think that depending on what frame choice has been made, some consideration should be given to thickness equalization; after all, without some modification the right lens would end up being more than twice the edge thickness of the left, which would probably be unacceptable to a patient, especially if the frame choice happens to be a three-piece, rimless drill mount. Do you have any other observations to share? Do you notice anything else? Did it dawn on you to say that this patient's prescription - while myopic, astigmatic, and presbyopic - is also anisometropic? Probably not.

Consider the following Rx:

O.D. + 2.00 – 1.00 x 090 / add +2.50
O.S. – 0.25 – 1.50 x 090 / add +2.25

Again, if asked to share all of your observations about this Rx and the patient to whom it belongs, what are some of the things you might say? You would no doubt say that, upon first observation, that this prescription is a little unusual. You would also notice that the patient is hyperopic (farsighted) in the right eye, and myopic in the left. You might observe that the axis of the cylindrical correction of the right eye is the same as the axis of the cylindrical correction of the left eye. This patient is also presbyopic, and requires a different near add in each eye. Though not unheard of, this is a bit unusual. Due to the difference in correction in each eye, you might

start to think about the cosmetics of the final job. You might also say that you would call the prescriber's office to verify the unlike signs of the sphere, the differing adds, and to perhaps inquire about past eyeglass preferences. Do you have any other observations to share? Do you notice anything else? Did it dawn on you to say that this patient's prescription – while hyperopic, myopic, astigmatic, presbyopic, and unusual - is also antimetropic? Probably not.

The technical definition of *anisometropia* is a condition in which the two eyes have unequal refractive powers, meaning they are in different states of myopia or hyperopia, such as in the first example. In the extreme, the eyes have unequal refractive powers, that is, one eye is myopic and the other is hyperopic. This condition is called *antimetropia*, as in the second example.

Based on those definitions, consider the following ten single-vision prescriptions. Place an "x" on the line for each prescription that is anisometropic. Place an "o" on the line for each prescription that is antimetropic. If the prescription is neither anisometropic or antimetropic leave the line blank.

1.____ O.D. – 2.50 – 2.25 x 010; O.S. – 1.50 sphere

2.____ O.D. – 1.00 – 0.25 x 155; O.S. – 2.00 – 1.00 x 122

3.____ O.D. +.50 sphere; O.S. +1.00 sphere

4.____ O.D. +1.50 – 1.00 x 085; O.S. +.50 + 1.00 x 175

5.____ O.D. – 5.75 – 0.50 x 100; O.S. – 4.00 sphere

6.____ O.D. – 0.75 – 0.50 x 123; O.S. + 0.50 – 0.25 x 005

7.____ O.D. +2.25 – 0.50 x 007; O.S. – 1.25 – 1.25 x 090

8.____ O.D. – 1.25 – 1.25 x 090; O.S. – 1.25 – 1.25 x 090

9.____ O.D. – 10.25 – 1.00 x 077; O.S. – 8.75 sphere

10.____ O.D. +0.75 sphere; O.S. +0.75 sphere

To more fully understand the meaning of these two conditions, one must only dissect the syllables of each word and understand their origins. The words are made up of four Greek elements. "An" means "not;" "iso" means "same;" "metr" means "measure;" and "opia" means "eye." Therefore, anisometropia simply means "not the same measure in each eye." Consider the three Greek elements that together form the word antimetropia. "Anti" means "against" (or differing); "metr" means "measure;" and "opia" means "eye." Therefore, antimetropia simply means "different measure in each eye."

In most cases, left uncorrected, differing rotations caused by significant anisometropia or antimetropia could lead to *diplopia* (double vision) or *asthenopia* (eye strain). Anisometropia can

negatively impact the development of functional binocular vision in infants and children, resulting in a condition known as *amblyopia*, more commonly known as lazy eye. It is estimated that 6-8% of American children between the ages of 6-18 have some degree of amblyopia, while 2-3% of the total American population is affected.

II Amblyopia

As stated above, amblyopia is more commonly known as "lazy eye." Although only a relatively small percentage of people are amblyopic, left uncorrected, it can have devastating consequences for the people who are affected. Left uncorrected, central vision will fail to develop in one eye, which is then referred to as the amblyopic (or "lazy") eye. Left untreated, amblyopia can lead to functional blindness in the affected eye. Although the amblyopic eye technically has the ability to see, the brain in essence disregards all information sent to it from the lazy eye, because it is "faulty" information. The images sent from the "bad" eye are blurry, so the brain tends to go with the images sent by the "good" or dominant eye. Since this condition usually develops before the age of six, parents, other family members, teachers, or day-care workers are usually the ones who first notice the signs and symptoms of amblyopia. These may include general overall poor visual acuity, eyestrain, headaches, squinting, or even intermittently closing of one eye.

Amblyopic children can be treated with vision therapy (which often includes patching one eye), atropine eye drops, the correct prescription for nearsightedness or farsightedness, or in extreme cases even surgery. The causes of amblyopia include a variety of uncorrected refractive errors (including myopia or hyperopia), some kind of ocular trauma, or *strabismus*.

Strabismus is a condition in which the eyes do not look toward an object together. One eye looks at the object normally, while the other eye looks in (esotropia), out (exotropia), up (hypertropia), or down (hypotropia). A patient affected by esotropic strabismus is sometimes said to have crossed eyes. Strabismus is caused by an irregular pulling or paralysis of the ocular muscles. Many infants appear to have crossed eyes. This is simply due to undeveloped vision and is not true strabismus. True strabismus will not disappear as the child matures.

One of the best resources for kids and parents living with amblyopia is The Eye Patch Club, sponsored by Prevent Blindness America. Its newsletter, *The Eye Patch Club News*, features tips and techniques for promoting compliance, stories from and about children who are patching, and helpful advice from eye care professionals. The newsletter also includes a Kid's Page with fun games and puzzles for children. You may access this free, worthwhile resource using the following link: http://www.preventblindness.org/children/EyePatchClub.html. If you have access to the Internet, take a few minutes right now to familiarize yourself with this resource and perhaps begin to recommend it to your clients.

III Significant Anisometropia

As the ten prescriptions in the introductory section clearly illustrate, going by the strict definition of anisometropia, the majority of spectacle prescriptions in existence these days could be considered anisometropic. As front-line eye care professionals, dispensing opticians must be able to differentiate between significant anisometropia and insignificant anisometropia. For the purposes of this module, we will define *significant anisometropia* as a prescription that requires something other than a typical solution to correct for it; simple convex, concave, or cylindrical lenses will not suffice.

If faced with the following five spectacle prescriptions/scenarios, which one(s) would you think should be considered "significant anisometropia," in that you would suggest a special correction (e.g. a slab-off grind) for your patient? Place an "x" on the line for each that you think do require that kind of special attention; if not, leave the line blank.

1. ____ A 16-year old girl with the following Rx:
   OD: + 1.75 sphere = 20/20

   OS: - 3.00 -1.00 x 090 = 20/25+

2. ____ A 43-year old emerging presbyope purchasing his first pair of progressive lenses, with the following Rx:
   OD: + 2.75 - 1.00 x 023; add +1.75 = 20/30-2
   OS: +1.00 sphere; add +1.75 = 20/20-1

3. ____ A 53-year old patient who has been successfully wearing the following Rx in Varilux Comfort, polycarbonate lenses with no slab-off prism for the past three years:
   OD: -5.50 - 2.00 x 153; add +2.25 = 20/20
   OS: +2.00 - 1.00 x 005; add +2.25 = 20/25-1; whose prescription has now changed to the following:
   OD: -7.00 -1.00 x 155; add +2.75 = 20/20
   OS: +2.50-1.25 x 069; add +2.75 = 20/20

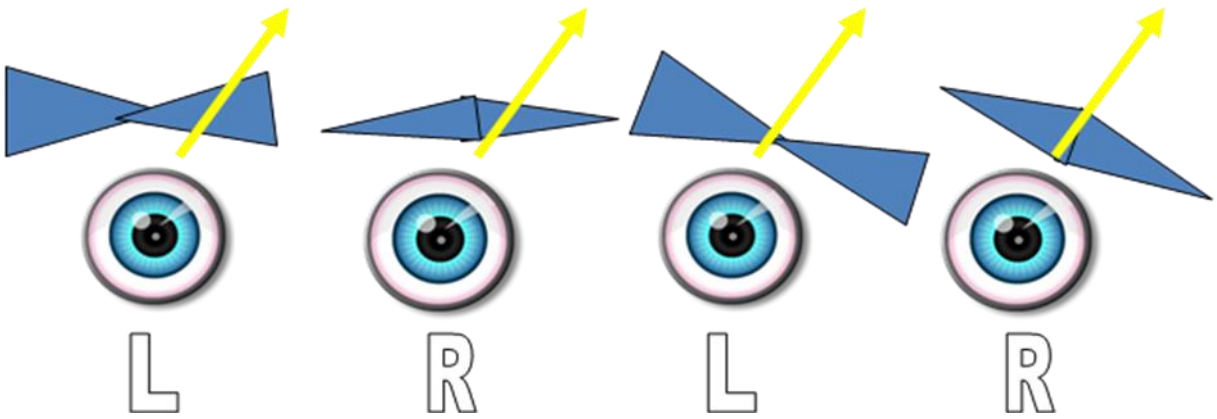
4. ___ An 8-year old girl who will soon be wearing her first pair of prescription, single-vision eyeglass lenses. Here is her Rx:
   OD: -2.25 sphere = 20/15
   OS -+3.00 - 1.50 x 090 = 20/20

5. ___ A 61-year old man who is ordering his first pair of prescription eyeglasses following a successful intraocular lens implant in his right eye. The patient's ophthalmologist has informed him that his left eye only has a "baby cataract," that will probably not be "ripe" for another three years. Here is his prescription:
   OD: -1.00 - 0.50 x 090; add +2.50 = 20/20-2

   OS: +4.50 sphere; add +2.50 = 20/30

The only example above that should have an “x” next to it is number five. Let’s look at the other four and figure out why they do not warrant any “special” considerations.

In the first example, a 16-year old girl who has excellent acuity with her correction has a prescription with significant anisometropia. The disparity in the corrections means that if she glanced 10mm away from optical center, for example, she would experience an imbalance of 3.75 diopters – surely enough that it gets our attention. However, when she does have occasion to glance 10mm away from optical center, she will simply and naturally rotate her head to follow, meaning that she will once again be looking through the optical center of both lenses. Therefore, she should not experience any problem. This phenomenon is illustrated below, in Figure 1.



(Figure 1)

As illustrated and explained above, single-vision prescriptions will rarely require a special correction to deal with anisometropia. The patient merely has to turn her head to “correct” the problem. One exception to this would be a patient who is physically unable to turn her head. Perhaps she is immobile due to an accident or disability.

The emerging presbyope in the second example has very good corrected visual acuity, and when glancing through the progressive lenses at near he will deviate from the optical center. Unlike someone wearing single-vision lenses, this patient cannot simply “correct” any problems resulting from deviation from optical center by moving his head. So, someone wearing a multifocal with an anisometropic correction needs to have an optician who understands the problems that may arise. The only question with this patient is: Is the anisometropia *significant* enough that it requires supplemental correction? Probably not, since there is only about 1 diopter of vertical imbalance.

On paper, the patient in example #3 seems to require some special consideration, in that she has significant vertical imbalance with a multifocal correction, and good corrected visual acuity. However, she has apparently been able to successfully wear a standard correction in the past. Upon further questioning, if the patient has been happy and has not experienced any

difficulty in the past: If it ain't broke, don't fix it. She will probably do just fine with a standard correction.

The fourth example is similar to the first.

The fifth and final example should indeed raise the concern of any eye care professional, for many reasons. The patient's corrected visual acuity is good; considering the situation one might say great. There is a vertical imbalance of 5.5 diopters. It is a multifocal correction. Apparently, the patient will have to live with this correction for at least a year. This seems like "the perfect storm." All of these characteristics converge to potentially create problems for the patient, unless his eye care professional successfully recommends a supplementary correction. In this case either a slab-off or wearing two separate pairs of eyeglasses (one for reading and one for distance) will effectively solve the problem.

Lately, when I work on the front line of my dispensary, I am seeing more and more patients in the same situation as the hypothetical patient in scenario #5, and I'm sure you do too. Therefore, let's now look more comprehensively at what the problems are, how to identify potentially problem prescriptions, and how to guide our patients to the best solution.

IV Patients Troubled by Anisometropia

Most people with any prismatic imbalance have some trouble or discomfort, but people wearing only single-vision glasses are generally not affected by it. Remember, that regardless of power or disparity of power from lens to lens, when a patient looks through the optical center of a lens, there is zero prismatic effect. As stated earlier, most people wearing single-vision lenses simply turn or rotate their head when looking side to side or up and down, no problem occurs.

Another consideration is that imbalance in the 90th meridian (vertically) is significant. Although some presbyopic patients seem to tolerate significant uncorrected vertical imbalance, from a "textbook" standpoint, more than 1.5 diopters of prismatic imbalance requires special correction and consideration. Uncorrected, visual acuity and clarity at near will be compromised. Why? Remember that prism bends light toward its base, while at the same time it will displace any images viewed through it toward its apex. In considering patient problems in the 90th meridian, the "image" we are concerned with is usually a horizontal line of print, while the patient is reading or working at near, looking through the add portion of the lens. As a patient focuses on a line of print at near, the base up prism of one lens displaces the line of print in a downward direction, while the base down prism of the other lens displaces the line of print in an upward direction. Left uncorrected, the patient will face the challenge of reading horizontally split lines of print in a newspaper or book. This may be perceived as follows:

Patients who have good visual acuity in only one eye are generally not candidates for special correction of vertical imbalance. As discussed earlier, in these cases the brain essentially "turns off" messages sent to it by the weaker eye. In summary, patients who may require a special correction are multifocal wearers with good visual acuity in both eyes, suffering with a vertical prismatic imbalance of more than 1.5 diopters.

V Identifying "Problem" Prescriptions

The first thing an optician should consider in the dispensing process is the relationship between the patient's new prescription and what she has been previously wearing. If the amount of vertical imbalance caused by the new prescription is less than or equal to the old, a special correction will probably not be required. The patient has been wearing single-vision lenses, but now wants to wear only one pair of flat-top 28s. This might cause potential problems. The point being, despite all of the formulas and guidelines, the judgment of the eye care professional is paramount in deciding what course of action a patient should take.

In order to determine whether or not a patient is experiencing 1.5 diopters or more of vertical imbalance, an eye care professional will first have to determine the exact power of the lens in the 90th meridian. The information necessary to determine this is the patient's prescription, reading depth, and the application of optical formulas we learned in school or as apprentices. Since the reading depth is usually identical eye for eye, using a "standard" drop of 10mm in our determination makes sense. Consider the following prescription:

OD: - 1.50 sphere / +2.50 add
OS: + 2.00 sphere / +2.50 add

Using simple math, we determine that the total reading power in the 90th meridian for this patient would be as follows:

OD: + 1.00 sphere
OS: + 4.50 sphere

At this point, do not think addition or subtraction. Rather, think of a number line:

6 5 4 3 2 1 0 1 2 3 4 5 6

←----------→

- (Minus) + (Plus)

Looking at it this way, we see that the "distance" from the point "+1.00" to the point "+4.50" is 3.5. Therefore, left uncorrected, this patient would be experiencing a probably intolerable vertical imbalance of 3.5 diopters. Let's try another one:

OD: - 2.50 sphere / +1.50 add
OS: + 2.50 sphere / +1.50 add

Again, using simple math, we determine that the total reading power in the 90th meridian for this patient would be as follows:

OD: - 1.00 sphere
OS: + 4.00 sphere

Using the number line approach, we see that the "distance" from the point "-1.00" to the point "+4.00" is 5.00. Therefore, left uncorrected, the patient would be experiencing an intolerable vertical imbalance of 5.00 diopters.

Based on what we have just learned, and using the "number line method," determine what (if any) vertical imbalance is present in the following examples, all of which are spherical corrections with the same add in both eyes. (For the purpose of this exercise, assume a corrected acuity of 20/30 or better in each eye.) Additionally, circle "yes" or "no" depending if you think the patient would or would not require special correction to deal with the imbalance:

Prescription	Imbalance		
1. OD: +1.00; OS: +3.25; +4.00 add	_____	Yes	No
2. OD: +3.75; OS: +2.75; +2.00 add	_____	Yes	No
3. OD: -5.50; OS: Plano; +2.25 add	_____	Yes	No
4. OD: Plano; OS: +1.50; +2.75 add	_____	Yes	No
5. OD: -2.50; OS: +1.75; +2.00 add	_____	Yes	No
6. OD: -2.75; OS: +1.75; +2.50 add	_____	Yes	No
7. OD: -1.50; +2.00; single vision	_____	Yes	No
8. OD: -0.25; +3.25; +1.75 add	_____	Yes	No
9. OD: -2.00; +2.00; single vision	_____	Yes	No
10. OD: +2.00; -2.00; +2.00 add	_____	Yes	No

In all of the examples above, the corrections were spherical in both eyes. When the patient's distance prescription is compound (including some correction for astigmatism) instead, the formula is not as straightforward, but still easily determined. Consider the following reference table:

0 degrees away from the axis of the Rx, there is 0 times the cylinder power.
30 degrees away from the axis of the Rx there is .25 times the cylinder power.
45 degrees away from the axis of the Rx there is .50 times the cylinder power.
60 degrees away from the axis of the Rx there is .75 times the cylinder power.
90 degrees away from the axis of the Rx there is 1 times the cylinder power.

While there is a specific, complex mathematical formula for determining power at every axis, the table shown above should be enough for an optician to closely estimate power in the 90th meridian of a lens. (Remember, the axis of the cylindrical correction must be added to or subtracted from axis 90 – the vertical meridian.) Consider the following example:

OD: +2.50 – 1.00 x 028; +2.00 add
OS: Plano – 1.50 x 043; +2.00 add

By using simple math, information from the chart just introduced, and the "number line method" we used in the spherical examples, we can determine whether the patient needs special correction or not. Let's do the work: In the right eye, the spherical power is +2.50. The cylindrical power is -1.00 at axis 30 (more or less), which is 60 degrees away from the vertical, or 90th meridian. Remember, we are always concerned with the power at axis 90. So, according to the chart, 60 degrees away from the axis of the cylinder power there is .75 times (three fourths) the power present, or -.75 in this case. Algebraically add +2.50 and -.75 and we determine in this lens the power in the 90th meridian is +1.75 diopters in the right eye. In the left eye the spherical power is plano, or zero. The cylindrical power is -1.50 at axis 45 (more or less), which is 45 degrees away from the vertical, or 90th meridian. So, according to the chart, 45 degrees away from the axis of the cylinder power there is .50 (half) the power present, or -0.75 diopters. Algebraically add zero and -.75 and we determine that the power in the 90th meridian of the left eye is -0.75. Using the number line method, we determine that the "distance" from point "+1.75" to point "-0.75" is 2.50. Therefore, left uncorrected, this patient will experience 1.00 diopter more vertical imbalance than the textbook tolerance of 1.5 diopters of imbalance. Since the add powers are the same, we did not need to include them in the equation. (Had we included them in the equation, the answer would have been the same.) Let's do one more. Consider the following Rx:

OD: +2.00 – 4.50 x 180; +2.50 add
OS: -1.50 – 2.75 x 090; +2.50 add

In the right eye, the spherical power is +2.00. The cylindrical power is -4.50 at axis 180, which is 90 degrees away from the vertical, or 90th meridian. So, according to the chart, that means the entire cylindrical power must be taken into consideration. Algebraically add +2.00 and -4.50, and we determine the power in the 90th meridian in the right eye is -2.50. In the left eye, the spherical power is -1.50. The cylindrical power is -2.75 at axis 90, which is zero degrees away from the 90th meridian, meaning that none of the cylindrical power needs to be considered. Therefore, in the left eye the power in the vertical meridian is -1.50. Using the number line method we

determine that the "distance" from point "-2.50" to point "-1.50" is 1.00 diopter of vertical imbalance, which would not require any special attention. Once again, you will notice that it is not necessary to consider the add power, since it is the same in both eyes. If the add power is different, then it should become part of the calculation.

Determine the vertical imbalance (if any) of the following compound prescriptions, and determine whether or not special correction will likely be necessary. For the purpose of determining this, assume that each patient has corrected acuities at or near 20/20:

	Prescription	Imbalance		
1.	OD: +2.00 – 1.50 x 088 / +2.50 add OS: -1.00 – 1.00 x 090 / +2.50 add	_____	Yes	No
2.	OD: +6.75 sphere / +2.50 add OS: +1.00 – 1.50 x 135 / +2.50 add	_____	Yes	No
3.	OD: +3.00 – 2.50 x 175 / +3.00 add OS: - 1.25 – 1.00 x 090 / +2.50 add	_____	Yes	No
4.	OD: -1.75 – 2.00 x 045 / +1.25 add OS: - 8.50 sphere / +1.25 add	_____	Yes	No
5.	OD: Plano -5.00 x 180 / +3.00 add OS: -5.00 +2.50 x 090 / +3.00 add	_____	Yes	No
6.	OD: +6.25 – 1.50 x 135 / +2.50 add OS: +2.50 – 1.00 x 090 / +2.50 add	_____	Yes	No
7.	OD: -7.50 -1.00 x 045 / +1.75 add OS: -12.50 – 3.25 x 090 / +1.75 add	_____	Yes	No
8.	OD: Plano / +3.00 add OS: +3.00 – 1.00 x 180 / +3.00 add	_____	Yes	No
9.	OD: +2.75 – 1.00 x 090 / +1.00 add OS: +3.00 sphere / +1.00 add	_____	Yes	No

10. OD: +8.00 – 4.75 x 180 / +3.00 add
OS: +10.50 -3.00 x 150 / +3.00 add _____ Yes No

Even though we have not called it by its name yet, in determining whether we should consider special corrections, we have been using one of the first optical formulas we learned – Prentice's Rule. This is the formula that gives us a close approximation of the amount of prism present at any point on a lens based on the dioptric power of the lens and the distance away from its optical center. Although there are some variations, Prentice's Rule is most commonly written as: P = cf; where "P" is the amount of prism, "c" is the decentration (in centimeters), and "f" is the lens power in diopters. The one unusual component of the traditional rule is, of course, centimeters. As opticians, we more commonly work in millimeters. So a more practical Prentice's Rule for opticians might be expressed as: P = dD/10; where P = prism; d = distance from optical center; D = dioptric power; divided by ten.

To further understand the appropriate direction of prism on a lens, some opticians also find "diagramming" it to be extremely helpful. In order to appreciate what is meant by diagramming, it may help to remember that at the optical center of any given lens, there is no prismatic effect at all. At points a short distance from the optical center there is a slight prismatic effect. At points farther away from the optical center there is a greater prismatic effect. Therefore, we could say that the curved surface of a lens is made up of a series of very short straight sides angled a bit more than the side adjacent to it, all coming together at the optical center of the lens. Since a prism is symbolized as a triangle, and a lens that corrects hyperopia (a plus, convex lens) is thickest at its center and thinner toward its periphery, we can deduce that a plus lens is made up of a series of prisms with their bases oriented toward the center of the lens (figure 2).

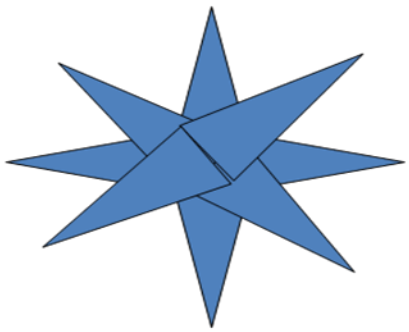


Figure 2

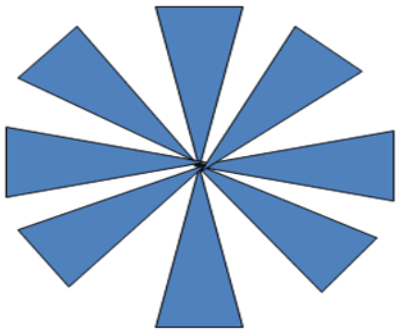


Figure 3

Likewise, since a lens that corrects for myopia (a minus, concave lens) is thinnest at its center and thicker toward its periphery, we can deduce that a minus lens is made up of a series of prisms with their apices oriented toward the center of the lens (figure 3).

In most cases, prism is prescribed either up or down (vertical), or in or out (horizontal). So when diagramming to determine the direction of prism, an optician needs to use a template as shown in figure 4 for a plus lens, and a template as illustrated in figure 5 for a minus lens.

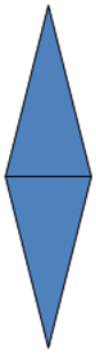


Figure 4

Figure 5

Consider the following question and diagram. (In the diagrams, "x" represents the optical center of the lens, and "o" represents the point on the lens where we are attempting to determine the amount of prism that is present.)

How much prism is present 5mm below the optical center of on a +4.50 lens?

Use the amended Prentice's Rule learned above and the appropriate diagram (figure 6) to determine the amount and direction of prism. 4.50 x 5 = 22.5. 22.5 divided by 10 = 2.25 diopters of prism. By simply noting the point on the lens relative to the base of the prism, we now know that at the point of the lens in question has 2.25 diopters of prism, base up.

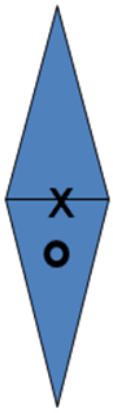
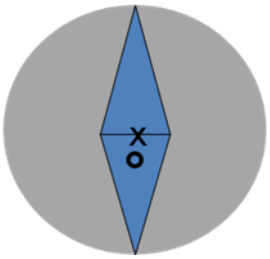


Figure 6

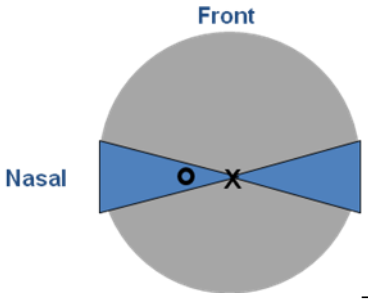
In order to develop a better understanding of the methods discussed in determining the prismatic effect, take a few minutes to answer the following six questions using both Prentice's Rule and the diagramming method. Place your answer on the line to the right of the diagramming triangle, and show your work.

1. What amount of prism is present 2 mm below the optical center of a +8.50 D lens?



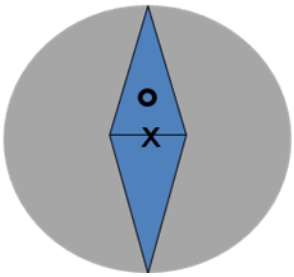
_____ Base _____

2. What amount of prism is the patient experiencing if the optical center is moved 5 mm out toward the temple on a -3.25 lens?



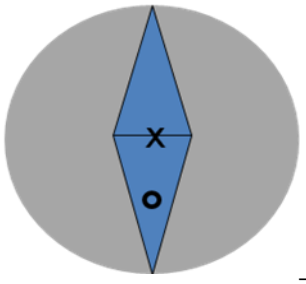
_____ Base _____

3. The optical center is 4 mm below the pupil on a +7.75 lens. What, if any, prism is the patient experiencing?



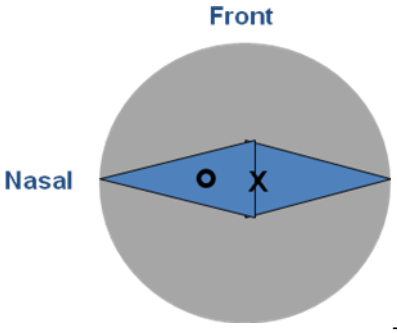
_____ Base _____

4. The Rx is +5.00 – 1.50 x 090. What amount of prism is present 8 mm below the optical center of the lens?



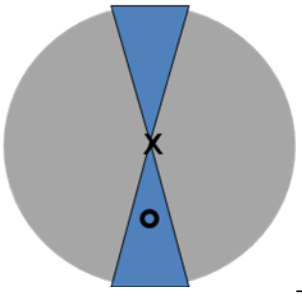
_____ Base _____

5. The Rx is +5.00 – 1.50 x 090. If the optical center is decentered out 5 mm from the patient's pupil, what amount of prism is present?



_____ Base _____

6. The Rx is -10.00 -2.75 x 045. What prism is present if the wearer looks down through the lens at a point 6 mm below the optical center?



_____ Base _____

7 Steps to Identify a Problem Rx:

1. Make sure both lenses are either in plus or minus cylinder form.
2. Determine lens power in the 90th (vertical) meridian.
3. If reading depth is the same, use 10mm as a constant.
4. Using Prentice's Rule, determine prismatic effect on each lens.
5. Use prism diagramming to identify the direction of the prism.
6. Consult with the prescriber and/or the patient to determine previous correction.
7. As an eye care professional, make your decision as to the best course of action.

Ironically, perhaps the most overlooked step by eye care practitioners is number 7. Your knowledge, experience, and communication with the prescriber and the patient are of paramount importance. Additionally, when educating patients, be sure to avoid technical language and jargon like "bi-centric grinding," "prismatic effect," and "anisometropia." Describe the problem and its possible solutions in simple, easy-to-understand, laymen's terms when speaking with your patients.

6 Contraindications for Correcting Vertical Imbalance

1. Single-vision wearers.
2. Contact lens wearers.
3. Patients with one eye.
4. Patients with good acuity in one eye only.
5. Patients who have tolerated high degrees of uncorrected vertical imbalance in the past without special correction.
6. Patients with less than 1.5 diopters of vertical imbalance

Patients who fall into any one of those six categories would not require any special attention; for all others…

VI Methods of Correcting Vertical Imbalance

There are several methods of correcting vertical imbalance. Let's delve into a few different methods and consider their applicability and viability in the 21st century, in terms of their basic advantages and disadvantages.

1. **Dissimilar Segments.** The method of using dissimilar segment styles is usually implemented by placing an executive lens in front of the eye that has the most

minus correction. An executive-style bifocal will naturally generate base-up prism in the reading portion of the lens by virtue of the fact that the optical center of the lens is located on the segment line. When that is used in conjunction with the naturally generated base-down prism in the upper or distance portion of the lens, a cancelling effect occurs, thereby reducing the prismatic difference between the patient's distance and near correction.

The other lens accomplishes the same thing by using an ultex lens in the most plus lens. Since the optical center of an ultex is at the very bottom of the lens (far below an average person's reading gaze) the base down prism of the segment reduces some of the base up of the distance portion. This "dissimilar segments" method mechanically manipulates the prism to make the lenses more compatible with one another – making reading more tolerable for the anisometropic patient. The advantage of using the dissimilar segments solution is that it is inexpensive and requires no special surfacing or edging. However, this method has one, hard-to-overcome disadvantage: While this method used to be implemented quite successfully in decades past, these days it is impractical at best. Why? Nearly 75% of multifocal wearers in America prefer progressive, no-line multifocals. Additionally, with more of an emphasis on style these days, dissimilar segments are unacceptable to most of our clientele. They would not accept the cosmetics, or more accurately the lack thereof, using dissimilar, lined bifocals.

2. **Single-Vision Eyeglasses.** One thing many opticians are unaware of is that bi-centric grinding (more commonly referred to as slab-off and discussed in the next two paragraphs) usually will not correct for a vertical imbalance that exceeds five or six diopters. In cases with severe vertical imbalance, single-vision glasses are the only viable solution to the problem. When choosing this method to correct vertical imbalance, an optician must always remember to instruct the patient that she will have to direct her gaze by physically moving her head to bring it into alignment with the reading material or object being viewed at near. When this occurs, in essence the patient will be using the distance optical centers of the eyeglasses when focusing at near, thus avoiding any prismatic effect. If the optician fails to properly instruct the patient about moving her head instead of her eyes, the patient may not be happy with the correction. The obvious advantages of the single-vision method are that it can easily and effectively correct high levels of vertical imbalance, and that it is fairly inexpensive. This method has a few disadvantages to be sure. First, the patient will have to constantly switch between distance and reading glasses. If the patient chooses full-size reading glasses she will have to drop her head, and if she chooses half-eyes she will require some other distance correction – for example, contact lenses.

3. **Slab-Off.** The most frequent solution to vertical imbalance is slab-off, or bi-centric grinding. For cases of vertical imbalance six diopters or less, some type of slabbing off the lens is the most exacting way to correct it. There are many different ways of slabbing off a lens, and while the process is quite complex, the optical theory that makes it work is beautifully simple. As we have already

learned, a given amount of base up prism in the right eye, when used in conjunction with the same amount of base down prism in the left eye, will have a *compounding* effect, resulting in an imbalance with which the patient would have to cope.

Likewise, a given amount of prism base up or down when added to an equal amount of prism in the same direction in the other eye will have a *cancelling* effect. For example, two diopters of base-up prism in the right eye used in conjunction with two diopters of base-up prism in the left eye will have a cancelling effect. Thus, in this example, the patient will experience no vertical imbalance. In summary, when prisms that are opposite in both eyes are combined, they will compound; but if those same opposite prisms are combined in the same eye, they will have a cancelling effect.

So slab-off uses the cancelling effect of opposite prisms to eliminate the problems associated with vertical imbalance for the patient. First, figure out the total amount of vertical imbalance. Second, we use base-up prism equal to the total imbalance of the prescription in the more minus or base-down component of the prescription. The base-up prism that is ground in the minus, base-down lens has a superimposing or cancelling effect on the imbalance in that eye. Third, the base-up prism ground in the minus, base-down lens places the opposing directions on top of one another, having a cancelling effect in that eye. Fourth, the remaining base-up prism in that eye is equal to the base-up prism in the other eye and therefore has a cancelling effect on it. That means all imbalance has been cancelled and the patient can read without any optical distractions at near.

The advantages of using a slab-off are that it is capable of neutralizing up to 5 diopters of vertical imbalance, it can be ground on any type of multifocal and lens material, and is not too cosmetically unappealing. (Although the process produces a horizontal line across the lens, it is relatively faint.) The disadvantages are that it usually take a little longer to process the patient's order because it has to be sent to a specialty lab; additionally, it is fairly costly, usually adding more than $100 to the total cost of eyeglasses.

4. **Reverse Slab-Off.** Some labs that specialize in correcting vertical imbalance prefer to use what is called a reverse slab-off. It achieves the same goal of a ground slab-off (neutralizing all vertical imbalance), but it does so by simply molding base-down prism in the more plus lens, which is why it is called a *reverse* slab-off. The molded, base-down lens superimposes and cancels the base-up component of the imbalance with the base-down prism, matching and cancelling the base down prism in the opposite eye. The advantage of a reverse slab-off is that the molded nature of the lens blank means that no special surfacing is necessary. Additionally, a reverse slab-off can neutralize up to 6 diopters of imbalance, and cosmetically it is no less appealing than a standard slab-off. Just like the slab-off, cost is an issue here. Finally, another disadvantage to a reverse slab-off is that it can only be applied to multifocals that use a straight-top design.

VII Case Studies

For the following six case studies, determine first, the amount (if any) of vertical imbalance present. Then circle "yes" or "no" in answer to the question: Should this patient consider a slab-off to correct the imbalance? Finally, in the space provided, briefly detail why, or why not.

Case Study #1: A middle-aged patient who has lost his old eyeglasses. You have no access to his optical history, but he informs you that he has never been able to see "anything other than shadows" out of his left eye.

OD: +3.00 -1.00 x 090 = 20/20-1
OS: -1.50 sphere = 20/200
Add: +2.00 OU; FT-28

Vertical Imbalance: _____
Slab-Off: Yes No
Explanation: _____

Case Study #2: A teenager who wants single-vision, polarized, Gray-C sunglasses.

OD: -1.00 sphere = 20/20
OS: +3.00 sphere = 20/20
PD = 63

Vertical Imbalance: _____
Slab-Off: Yes No
Explanation: _____

Case Study #3: A 69-year old man who has just had IOL surgery in his left eye only. He is planning to have the cataract in his right eye removed in 12-14 months.

OD: -2.50 -1.00 x 121 = 20/40+
OS: +1.00 -1.00 x 180 = 20/20
Add: +2.50 OU

Vertical Imbalance: _____
Slab-Off: Yes No
Explanation: _____

Case Study #4: A 96-year old female patient who is wearing aphakic, lenticular, curve-top 25 lenses for the past 30 years. She has a slab-off OD. Her present Rx is:
OD: +14.00 sphere
OS: +18.00 -1.00 x 026
Add: +3.00 OU

Her new Rx is:

OD: +15.00 -0.50 x 005 = 20/40-
OS: +19.00 -1.00 x 030 = 20/40+
Add: +3.50 OU

Vertical Imbalance: _____
Slab-Off: Yes No
Explanation: _____

Case Study #5: A 41-year old emerging presbyope who has been wearing single-vision, high-index lenses for distance correction only. His previous Rx is:
OD: +4.75 sphere
OS: +1.00 sphere

His new Rx is:

OD: +5.00 -0.50 x 090
OS: +1.25 -0.50 x 090
Add: +1.75 OU

Vertical Imbalance: _____
Slab-Off: Yes No
Explanation: _____

Case Study #6: The first spectacle prescription post IOL surgery for a 70-year old patient. She had an implant in the right eye and will have the left eye done @ 18 months. Here is her new prescription:

OD: Plano = 20/20+
OS: -5.00 +1.75 X 180 = 20/30-
Add: +2.50 OU

Vertical Imbalance: _____
Slab-Off: Yes No
Explanation:_____

Case Study #7: The first pair of spectacles for a bilateral, post IOL patient. The Rx:
OD: -2.00 -1.00 x 180 = 20/20
OS: Plano -2.00 x 090 = 20/20+
Add: +2.50 OU

Vertical Imbalance: _____
Slab-Off: Yes No
Explanation:_____

Case Study #8: A 44-year old tour guide who has been happily wearing FT-28s with no slab-off for several years. He has decided to try progressive lenses for the first time. His old Rx is:

OD: -4.25 sphere
OS: +6.25 -1.00 x 180
Add: +2.25 OU

Her new Rx:

OD: -3.75 sphere
OS: +5.00 -1.00 x 180
Add: +3.00 OU

Vertical Imbalance: _____
Slab-Off: Yes No
Explanation:_____

Case Study #9: First Rx, post IOL surgery OU:

OD: -0.50 -0.50 x 090 = 20/15
OS: -1.00 sphere = 20/20+2
Add: +2.75 OU

Vertical Imbalance: _____
Slab-Off: Yes No
Explanation:_____

Case Study #10: A middle-aged patient who complains of strain and occasional double-vision when reading. He is currently wearing FT-35s with no slab-off. His old Rx reads:
OD: -5.00 sphere = 20/20
OS: -4.50 -3.50 x 180 = 20/40
Add: +2.00 OU

His new Rx reads:

OD: -5.25 sphere = 20/20+
OS: -5.00 -4.00 x 178 = 20/30+
Add: =2.25 OU

Vertical Imbalance: _____
Slab-Off: Yes No
Explanation:_____

In conclusion, an eye care professional who realizes that he or she is going to be encountering more and more prescriptions that cause vertical imbalance in the coming years, and takes steps to brush up on how best to deal with it will have the upper hand. You will be seen as more knowledgeable and professional by your patients, and be more valuable for your boss and your practice. Before answering the questions in the final assessment, review the answers to all of the exercises and problems that were presented throughout this module. You will find them in Section VIII below.

VIII Answers to Module Questions

- For the 10 questions in Section I, asking whether the Rxs are anisometropic or antimetropic, you should have placed an "x" after numbers 1,2,3,4,5, and 9; you should have placed a "o" after numbers 6 and 7; there should be no mark at all after numbers 8 and 10.

- For the 5 scenarios in Section III, hopefully you placed an "x" after only number 5. The explanations for all five questions appear after the questions in Section III.

- For the first set of 10 questions in Section V, the answers are as follows:

1.	2.25	Yes
2.	1.00	No
3.	5.50	Yes
4.	1.50	Yes
5.	4.25	Yes
6.	4.50	Yes
7.	3.50	No
8.	3.50	Yes
9.	4.00	No
10.	4.00	Yes

- For the second set of 10 questions in Section V, the answers are as follows:

1.	3.00	Yes

2. 6.50 Yes

3. 2.25 Yes

4. 4.75 Yes

5. 0.00 No

6. 3.00 Yes

7. 4.50 Yes

8. 2.00 Yes

9. 0.25 No

10. 5.00 Yes

- For the third set of 6 questions in Section V, the answers are as follows:

1. 1.7 Base Up

2. 1.6 Base In

3. 3.1 Base Down

4. 4.0 Base Up

5. 1.75 Base Out

6. 6.80 Base Down

- For the Case Studies in Section VII, here are the answers and *suggested* explanations:

1. Vertical Imbalance: 4.5; Slab-off: No; Explanation: The poor visual acuity in the left eye means the vertical imbalance is not problematic.

2. Vertical Imbalance: 4.0; Slab-off: No; Explanation: It is a single-vision correction.

3. Vertical Imbalance: 2.75; Slab-off: Yes; Explanation: Acuities are good, and the patient would probably find it intolerable to function for a year without some special accommodation.

4. Vertical Imbalance: 4.25; Slab-off: Yes; Explanation: The new prescription contains more imbalance than the previous Rx, and the patient is already wearing a slab-off.

5. Vertical Imbalance: 3.75; Slab-off: Yes; Explanation: Since this is the patient's first multifocal correction, he will surely need some special correction due to nearly 4 diopters of imbalance.

6. Vertical Imbalance: 3.25; Slab-off: Yes; Explanation: Same as #3.

7. Vertical Imbalance: 3.00; Slab-off: Yes; Explanation: With nearly 3 diopters of imbalance, this post-IOL patient would probably not tolerate a standard correction.

8. Vertical Imbalance: 7.75; Slab-off: No; Explanation: Despite the extreme imbalance, the patient has happily "tolerated" even more imbalance without any apparent problems.

9. Vertical Imbalance: 0.50; Slab-off: No; Explanation: Imbalance is under 1.5 diopters.

10. Vertical Imbalance: 3.75; Slab-off: Yes; Explanation: He is already complaining of problems that are probably a result of uncorrected vertical imbalance. The new Rx improves acuity, and increases the imbalance. Uncorrected, his previous problems will only be compounded.

Author's Note: If you are happy with the results you achieved with these questions – great! If not, perhaps you might want to re-read this module, do some review and/or further studying. Though it's been around forever, one of the best resources is still *System for Ophthalmic Dispensing* by Clifford W. Brooks and Irvin M. Borish, particularly chapter 20: "Prism and Accommodating at Near." On the Internet just do a Google search using terms like "vertical imbalance in lenses," "Prentice's Rule," etc. If you have any questions, comments, or concerns about this CE module, I would love to hear from you, and (short of giving you the answers to the final assessment) I will help you any way I can. I also value your constructive feedback. My e-mail address is maxoptics@hotmail.com. My cell phone is (352) 848-4222. My mailing address is PO Box 5445, Spring Hill, FL 34611-5445. Good luck with your final assessment.

IX Final Assessment

1. Which of the following corrections for vertical imbalance would require a patient to consciously drop her head when reading, in order to appreciate the design of the correction?

    a. Dissimilar segments

    b. Single-vision reading glasses

    c. Slab-off

    d. Reverse slab-off

    e. None of the above

2. Base-down prism in a lens will displace a line of newspaper copy being viewed through that lens:

    a. Upward

    b. Downward

    c. Toward the O.C. of the lens

    d. Toward the periphery of the lens

3. Which of the following corrections would be best to correct 8 diopters of vertical imbalance?

    a. Dissimilar segments

    b. Two pairs of SV glasses – one for distance; one for near

    c. Slab-off

    d. Reverse slab-off

    e. None of the above

4. Which of the following spherical Rxs is antimetropic?

    a. OD: +1.50 sphere OS: -1.50 sphere

    b. OD +0.25 sphere OS: +3.75 sphere

c. OD: -2.50 sphere OS: -2.25 sphere

d. OD: -10.00 sphere OS: -7.75 sphere

e. All are antimetropic

f. None are antimetropic

5. How many diopters of vertical imbalance should an eye care professional consider significant enough to consider providing special correction for?

   a. 0.50

   b. 1.50

   c. 2.50

   d. 3.50

   e. 6.00

6. Which of the following spherical Rxs are anisometropic?

   a. OD: +1.50 sphere OS: -1.50 sphere

   b. OD: +0.25 sphere OS: +3.75 sphere

   c. OD: -2.50 sphere OS: -2.25 sphere

   d. OD: -10.00 sphere OS: -7.75 sphere

   e. All are anisometropic

   f. None are anisometropic

7. How many diopters (if any) of vertical imbalance is present in the following Rx at near?
   OD: +5.00 -1.00 x 180
   OS +7.00 sphere
   Add: +3.00 OU

   a. 0

   b. 1

   c. 2

d. 3

e. 4

8. Since it is usually the same in both eyes, what is not included in determining vertical imbalance?

   a. PDs

   b. Spherical powers

   c. Cylindrical powers

   d. Add power

   e. Axis of correction

9. Which of the following corrections come molded on the front surface of the lens?

   a. Slab-off

   b. Reverse slab-off

   c. Dissimilar segments

   d. Executive lenses

   e. None of the above

10. Which if the following lens materials will accept a slab-off?

   a. Crown glass

   b. CR-39

   c. Polycarbonate

   d. Trivex

   e. All of the above

   f. None of the above

11. Slab-off corrects for prismatic imbalance in which meridian of the lens?

a. 45-degrees

b. 60-degrees

c. 90-degrees

d. 180-degrees

12. How much cylinder power is present 90-degrees away from the axis of the prescription?

a. 25 %

b. 50 %

c. 75 %

d. 100 %

e. None

13. Vertical imbalance most often adversely affects vision at:

a. Night

b. The periphery

c. Distance

d. Near

e. None of the above

14. Which if the following corrections would be the most exacting and convenient method of correcting for a 4.5 diopters of vertical imbalance at near?

a. Dissimilar segments

b. Slab-off

c. Contacts for distance; readers for near

d. Two separate pairs of eyeglasses: one for distance; one for near

15. Which if the following would best correct for 6 diopters of vertical imbalance at near?

a. Reverse slab-off

b. Slab-off

c. Ultex/Executive combination

d. Lenticular lenses

16. The formula used to determine prismatic imbalance is:

a. Bowman's Rule of Thumb

b. Prentice's Rule

c. Vertex Compensation

d. Slab-Off Equations

17. Which of the following patient's acuities would be contraindicative in correcting a vertical imbalance of 3.75 diopters?

a. OD = 20/20 OS = 20/30

b. OD = 20/30+ OS = 20/200-

c. OD = 20/50+ OS = 20/40+

d. OD = 20/80 OS = 20/80

18. Which is always used on the "most minus" lens?

a. Slab-off

b. Reverse slab-off

c. Dissimilar segments

d. Press on prisms

19. How much cylinder power is present 45-degrees away from the axis of the Rx?

a. None

b. 25 %

c. 50 %

d. 75 %

e. 100 %

20. Amblyopia affects approximately what percent of American children?

a. 2-4 %

b. 4-5 %

c. 6-8 %

d. 8-10 %

e. 10-12 %

21. In the word anisometropia, “metr” means:

a. Different

b. Same

c. Measure

d. Eye

e. Acuity

22. OD: -1.00 -1.25 x 180 = 20/20
OS: -4.75 -2.00 x 090 = 20/30-
Add: +2.50 OU
In the above Rx, which component does not need to be factored in to determine vertical imbalance?

a. Add power

b. Cylinder power OD

c. Cylinder power OS

d. Axis

e. Acuities

23. In order to better “see” the direction of resultant prism on a lens, an optician should use which of the following techniques?

a. Prentice’s Rule

b. Diagramming

c. The Cancelling Method

d. The Compounding Method

24. A prism displaces objects being viewed through it toward its:

a. Apex

b. Vertex

c. Base

d. 90th Meridian

e. 180th Meridian

25. OD: +1.00 -1.00 x 180
OS: -2.50 sphere
Add: +1.75 OU
The above Rx is:

a. Unusual

b. Antimetropic

c. Anisometropic

d. Multifocal

e. Missing acuities

f. All of the above

g. None of the above

26. Assuming acuities of 2/20 OU; +2.50 add OU; reading depth 8mm OU. Which of the following Rxs contain the *most* vertical imbalance?

a. OD: +2.50 sphere OS: +1.50 -2.00 x 045

b. OD: -2.75 sphere OS: -4.75 +1.00 x 090

c. OD: +7.50 sphere OS: +3.50 +2.00 x 180

d. OD: -1.00 sphere OS: +2.00 sphere

e. OD: +1.00 sphere OS: +3.00 -3.00 x 044

27. Referring to the same choices in question 26, which one has the *least* vertical imbalance?

a. A

b. B

c. C

d. D

e. E

28. One way of thinking of a plus lens is that it is made up of an infinite number of prisms with their _____ oriented toward the optical center of the lens.

a. Apices

b. Bases

c. 180th meridians

d. 90th meridians

29. One way of thinking of a minus lens is that it is made up of an infinite number of prisms with their _____ oriented toward the optical center of the lens.

a. Apices

b. Bases

c. 180th meridians

d. 90th meridians

30. The best candidate for a slab-off correction is a patient with:

a. Good visual acuity in both eyes

b. Presbyopia

c. A vertical imbalance greater than 1.5 diopters

d. All of the above

e. None of the above

31. Which of the following does not need to be considered when determining vertical imbalance?

    a. Lens power in the 90th meridian

    b. Lens power in the 180th meridian

    c. Acuity

    d. Reading depth

    e. All are important determining factors

32. When speaking to your patient about the potential problems resulting from the vertical imbalance of his or her prescription, which of the following descriptive terms should be avoided?

    a. "Slabbing-off"

    b. "Bi-centric grinding"

    c. "Vertically imbalanced"

    d. "Diplopia"

    e. All of the above

    f. None of the above

33. Asthenopia is a technical, ocular term for:

    a. Eye strain

    b. Double vision

    c. Vertical imbalance

    d. Horizontal imbalance

34. What, if any, is the amount of vertical imbalance in the following prescription, at near?

    OD: +1.00 sphere
    OS: +2.50 -0.50 x 180
    OD Add: +2.00
    OS Add: +2.50

a. 1.0 diopters

b. 1.5 diopters

c. 2.0 diopters

d. 2.5 diopters

e. There is no vertical imbalance

35. If a 2.0 base-up prism is superimposed over a 2.0 base-down prism it will result in a vertical imbalance of:

a. Zero

b. 1 diopter

c. 2 diopters

d. 3 diopters

e. 4 diopters

36. The effect illustrated in Question #35 is called:

a. Prentice's Rule

b. Refractive Theory

c. Cancelling

d. Compounding

e. None of the above

37. If a 2.0 base-up prism is present in the patient's right lens, and a 2.0 base-down prism is ground into the left lens, it will result in a total vertical imbalance of:

a. Zero

b. 1 diopter

c. 2 diopters

d. 3 diopters

e. 4 diopters

38. The effect illustrated in Question #37 is called:

a. Prentice's Rule

b. Refractive Theory

c. Cancelling

d. Compounding

e. None of the above

39. If the left lens has a total reading power of +3.50 diopters in the 90th meridian, and the right lens has a total reading power of +1.00 in the 90th meridian, a slab-off should be considered.

a. True

b. False

40. The number of eyeglass jobs needing a correction for vertical imbalance processed in the coming years is likely to increase due to the number of expanding presbyopes, baby boomers, and IOL procedures

a. True

b. False

41. The technical term for lazy eye is:

a. Diplopia

b. Strabismus

c. Amblyopia

d. Asthenopia

e. None of the above

42. How much cylinder power is present 27 degrees away from the axis of correction? Approximately:

a. None

b. One-fourth

c. One-half

d. Three-fourths

e. All of it

43. Esotropia and hypotropia are manifestations of:

a. Strabismus

b. Nystagmus

c. Amblyopia

d. Asthenopia

e. None of the above

44. The Eye Patch Club is a great on-line resource for children dealing with:

a. Bullying

b. Presbyopia

c. Amblyopia

d. Exotropia

45. Slabbing-off a single-vision pair of eyeglasses might be considered:

a. Never. SV lenses never require a slab-off

b. If the patient is disabled, or if her head is immobile

c. If the vertical imbalance is greater than 10 diopters

d. If dissimilar segments did not work

46. Creating an opposing prism in a mold instead of grinding it on the lens is used with:

a. Plus lenses only

b. Minus lenses only

c. Reverse slab-offs

d. Standard slab-offs

47. Lens power: +3.00 -1.00 x 90; add +2.75. How much power is the patient experiencing when reading through the bifocal portion of this lens?

    a. +2.00 diopters

    b. +3.00 diopters

    c. +4.25 diopters

    d. +5.75 diopters

    e. None of the above

48. Lens power: -3.00 -1.00 x 180; add +2.75. How much power is the patient experiencing when reading through the bifocal portion of the lens?

    a. +0.25 diopters

    b. +1.25 diopters

    c. -0.25 diopters

    d. -1.25 diopters

    e. None of the above

49. Uncorrected vertical imbalance could cause:

    a. Asthenopia

    b. Diplopia

    c. Vision distortion

    d. All of the above

50. How far away from the optical center of a +2.00 spherical lens would the patient experience 1 diopter of prism?

    a. 2 mm

    b. 3 mm

    c. 4 mm

    d. 5 mm

    e. 6 mm

Answer Key for Anisometropia in the 21st Century

_____NAME _____License Number

Address:_____

Send only this sheet to CEDO Inc PO BOX 46486 Tampa, Fl 33646 or email to cedoinc@yahoo.com

1.	26
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STATE OF FLORIDA BOARD OF OPTICIANRY

NOTICE OF MEETING

TO: **CEDO, Inc.**
P.O. Box 46486
Tampa, Florida 33646

PLEASE TAKE NOTICE that CE Broker course #20-706479, "Anisometropia in the 21st Century", is on the October 23, 2020 agenda for review by the Board of Opticianry. The meeting is scheduled to begin at 9:00 A.M., EST via teleconference call. The dial-in information is:

Dial-in #: 1 (888) 585-9008 Participation Code: 123-475-828 #

You are not required to appear at this meeting. However, you are encouraged to attend. It may be helpful for you to appear in the event the Board has any questions concerning this review.

This is a public meeting and participants in this public meeting should be aware that these proceedings are being recorded and that an audio file of the meeting will be posted to the board's website.

CERTIFICATE OF SERVICE

I, HEREBY CERTIFY that a true and correct copy of the above and foregoing Notice of Meeting has been sent by U.S. Mail to the above address on this September 25, 2020.

Eric Pottschmidt
Program Operations Administrator
Email: Eric.Pottschmidt@flhealth.gov
Phone: (850) 245-4292, Facsimile: (850) 413-6982
4052 Bald Cypress Way, Bin # C08
Tallahassee, Florida 32399-3258

Course Summary

FLORIDA OPTOMETRIC ASSOCIATION

Course # 20-779946 - Creating Your Practice of Distinction

CE Committee Review Comments:

Review Required: Although every indication is that this is a good practice management course, I do not see that it is focused on opticianry or optical practice. Medical billing and increasing exams ultimately builds eyewear needs but this is not an hour beneficial for opticians.

Course Addition Request	
Course Name	Creating Your Practice of Distinction
CE Broker Course Tracking #	20 - 779946
Course Description	This course will discuss some of the challenges we face in eye care today. We will review how these challenges can create opportunity for our practice as well as for our patients. In addition, we will define distinction and what value can exist in creating distinction in our practice and our patient care. We will review examples of businesses outside the industry of optometry and how they have worked through challenges and excelled in customer service as well as profitability. We will outline specific strategies that can be taken to create distinction and produce better outcomes for our patients.
Provider	FLORIDA OPTOMETRIC ASSOCIATION
Course Type	Live
Delivery Method	Class
Provider Type	Board Approved Provider

Profession Selection + Hours	Renewal Hours	Approved Hours
Optician		
HIV/AIDS	0	
Medical Errors	0	
Technical Practice	0	
Elective	1	
Technical Practice (Contact Lens Theory and Practice)	0	
Laws and Rules of the Board (Initial Licensure or Renewal)	0	
Laws and Rules of the Board (Renewal Only, not for Initial Licensure)	0	
Laws and Rules of the Board (Apprentice Orientation)	0	
20-hour Board Certification Course (not taken to obtain Board Certification)	0	

Creating Your Practice of Distinction
Objectives/Abstract/Outline
Intermediate Level
April Jasper, OD, FAAO

Date: 7/18/20
Time: 8:00am-8:50am
Place: FOA 2020 Convention
Hours: 1 – ELECTIVE
Format: Live, classroom presentation
Times offered in the next 2 years: 1
Student-to-Teacher Ratio: max of 48 students
Classroom Rules: attendee must be present for 50 minutes per hour minimum; breaks should be minimized as to not reduce this; cell phones silenced

Summary: This course will discuss some of the challenges we face in eye care today. We will review how these challenges can create opportunity for our practice as well as for our patients. In addition, we will define distinction and what value can exist in creating distinction in our practice and our patient care. We will review examples of businesses outside the industry of optometry and how they have worked through challenges and excelled in customer service as well as profitability. We will outline specific strategies that can be taken to create distinction and produce better outcomes for our patients.

Course Objectives:

1. Discuss challenges we face in Optometry today
2. Describe how these challenges can be opportunities for our patients and our practice
3. Delineate strategies that are needed to excel within this era of challenge
4. Define Distinction in business
5. To review ways, we can create distinction in practice
6. Describe how one can grow practice by building relationships for better outcomes for patients.
7. Outline ways to wow our patients and create protocols resulting in greater patient satisfaction

Outline:

1) What really is involved in Today's Eye Care practice? 5 min
   a) Increased patients?
   b) Decreased reimbursement?
2) What will continue to change? 5 min
   a) More patients?
   b) Decreased reimbursements?
   c) Better educated patients

d) Increased internet purchasing
e) More pediatric patients
f) Greater attention to website by patients
g) More medical patients
h) Patient communication methods

3) What should be done in the optometric practice? 5 min
   a) Differentiation
   b) Education

4) What does it mean to differentiate? 5 min
   a) In business
   b) In Patient Care

5) Education options 5 min
   a) For Staff
   b) For Doctors
   c) For Patients

6) Strategies needed to excel in this new era 5 min
   a) Relationship building
   b) Interprofessional Communications
      i) Who to communicate with
         (1) Who does referrals
         (2) Who keeps track of records
      ii) What to communicate
      iii) How and When to communicate with other professionals
         (1) Types of letters required
         (2) Photos that help
         (3) Maps to office

7) How to adapt to the challenge of more patients 5 min
   a) Increase Efficiency in office
   b) More technology
   c) Larger Product offering
   d) Greater delegation
   e) Increase level of and frequency of Staff Training

8) How to adapt to the challenge of Decreased Reimbursements 5 min
   a) Sell more multiple pairs
   b) Increase number of CL fits
   c) Larger Product offering
   d) More medical billing
   e) Greater technology adaptation in the office

9) How to adapt to the challenge of Better Educated Patients 3 min
   a) Use technology to better educate patients in the office
   b) Give patients a summary of their findings after each visit
   c) Consistency with recommendations
   d) Larger selection of products
   e) Increase in prescribing of high end products in all areas of the office
10) How to adapt to the challenge of Increased Internet purchasing 3 min
   a) Give your patients internet options associated with your office
   b) Carry more high end products not available online
   c) Provide value other than product that create desire for patients to buy from you
   d) Bundle products so better able to compete with price
   e) Take away the element of fear so that purchases are made directly from you
11) How to adapt to the challenge of new insurance benefits 3 min
   a) Adapt checklist for Insurance verification to ensure staff discover benefit availability on medical plan
   b) Consider packages and promotions to increase upgrades and multiple pairs
12) How to adapt to the challenge of greater attention to website by patients 2 min
   a) Personalize your website
   b) Pay more attention to updating your website with videos and purchasing options
13) More medical patients 2 min
   a) Technology to enable you to better care for medical patients
      i) OCT'S
      ii) Retinal imaging
      iii) Autorefractor
      iv) More
   b) Increase skills in areas you are not currently familiar with
      i) Medical Eye Care
         (1) When
         (2) Who
         (3) How
      ii) Specialty Contact Lenses
         (1) When
         (2) Who
         (3) How
      iii) Ortho K
         (1) Types of lenses
         (2) Patients needs
         (3) Equipment needed

April L. Jasper, OD, FAAO

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Professional and Work Experience:

2002 - Present Doctor of Optometry, Advanced Eyecare Specialists, West Palm Beach, Florida. Acquired established private family practice/optical in August of 2002 and have increased gross revenues by over 300%. Our services include Contact lens fittings, Ocular disease diagnosis and treatment, pre and post-operative care and primary eye care.

2018 – Present Optometric Management Magazine, Chief Optometric Editor

2019 – Present Eyenovia, Chaperone Study, Medical Monitor
Eyenovia, Scientific Advisory Board

2019 – Present Optometric Management Education (OME) – Co-Founder/Education Director

2016 – 2018 Women in Optometry Magazine, Professional Co-Editor

2016 – 2017 Florida Optometric Association, President
The organization under my direction was involved in and directed legislative action under Chapter 463 staying aware of rulemaking and legislative decisions on an ongoing basis.

2008 - 2017 Vision Source Administrator, Southeast Florida (Ft. Pierce to Key West)
Responsible for growth in overall number of franchises in Vision Source and support the existing members with marketing, growth, and general management strategies.

2015 - 2016 Benedict Professor of Practice Management
University of Houston, College of Optometry

1996 - 2002 Independent Doctor of Optometry: Jasper Eye Care, Tallahassee, Florida
Family practice, Contact lenses, Ocular disease, post-operative care and primary eye care

1996 - 1997 Residency: Brockton/West Roxbury VAMC, Massachusetts
Specialty training in contact lens fitting of aphakic, keratoconic and post PK patients. Extensive work with post-operative cataract, oculo-plastics and glaucoma surgical cases. In-patient and out-patient care including spinal cord injury patients.

1996 - 1997 Assistant Clinical Professor: New England College of Optometry, Boston, MA. Assistant Instructor in Ocular Disease Lab. Assistant clinical instructor working with students seeing primary care and specialty contact lens patients.

1995 Externship: Bascom Palmer Eye Institute, Miami, FL. Extensive vision and eye health examining, therapeutic procedures.

SPEAKING/LECTURES:

2020	**- Jan**	OME – MythBusters: Myopia Edition CE – Springfield, IL
2019	**- Jan**	IDOC – The Connection National Conference – Orlando, FL
	- Feb	Alcon – Multifocal Contact Lens Presentation – Winter Haven, FL
	- Mar	Alcon – Multifocal Contact Lens Presentation – Ocala, FL
	- Apr	Oklahoma Optometric Association – CE Presentations – Norman, OK
		New Mexico Optometric Association – CE Presentations – Albuquerque, NM
		Alcon – Practitioners Visiting Alcon Presentations – Ft. Worth, TX
		Alcon – Multifocal Contact Lens Presentation – Orlando, FL
		Alcon – Multifocal Contact Lens Presentation – St. Augustine, FL
		Indiana Optometric Association – CE Presentations – French Lick, IN
		Alcon – Multifocal Contact Lens Presentation – Orlando, FL
		IDOC – CE Presentations – Phoenix, AZ
	- May	Vision Source Exchange 2019 – CE Presentation – Tampa, FL
		Alcon – Practitioners Visiting Alcon Presentations – Ft. Worth, TX
		Vold Vision – CE Presentations – Fayetteville, AR
		Connect-to-Grow Summit – CE Presentations – Anaheim, CA
		Connect-to-Grow Summit – CE Presentations – Oakland, CA
	- Jun	Alcon – Multifocal Contact Lens Presentations – Spring House, PA
		Alcon – Multifocal Contact Lens Presentations – York, PA
		IDOC – CE Presentations – New York, NY
		IDOC – CE Presentations – Columbus, OH
		Alcon – Multifocal Contact Lens Presentations – New Smyrna Beach, FL
	- Jul	OCuSOFT 1-Touch Presentation – Tampa, FL
		Florida Optometric Association – CE Presentations – Orlando, FL
		Alcon – Practitioners Visiting Alcon Presentations – Ft. Worth, TX
	- Aug	Alcon – Multifocal Contact Lens Presentations – Nashville, TN
	- Sept	Manasota Optometric Association – CE Presentations – Sarasota, FL
		Connect-to-Grow Summit – CE Presentations – Baltimore, MD
		Connect-to-Grow Summit – CE Presentations – Toronto, Canada
	- Oct	Alcon – Multifocal Contact Lens Presentations – Sanford, FL
		East West Eye – CE Presentations – Cleveland, OH
	- Nov	Connect-to-Grow Summit – CE Presentations – Ft. Lauderdale, FL
	- Dec	Optometric Management Symposium – CE Presentations – Orlando, FL
2018	**- Feb**	Practices of Distinction – Dallas, TX
		Lecture for S.N.A.P.P, SECO – Atlanta, GA
	- Mar	Alcon - Multifocal Contact Lens Presentations – Honolulu, HI
		Zeiss at Vision Expo East – CE & Exhibit Hall Booth Presentation – New York, NY
	- Apr	Alcon – Multifocal Contact Lens Presentation – Salt Lake City, UT
	- May	Alcon – Midwest Eye Consultants Presentation – New York, NY
	- Jun	Alcon & Lenscrafters/ALLDocs Lecture & Consultation – Akron, OH
	- Jul	FOA – 7 hrs. of CE Presentations – Orlando, FL
		FOA – 8 hrs. of Para-Optometric CE, Orlando, FL
	- Aug	Alcon – Multifocal Road Show – Jacksonville, FL
		Alcon – Multifocal Road Show – Orlando, FL
	- Sept	Alcon – Practitioners Visiting Alcon Presentation – Atlanta, GA
		ALLDocs – Annual Managers Meeting Facilitation – Nashville, TN

	- Oct	Alcon – Practitioners Visiting Alcon Presentation – Atlanta, GA
	- Nov	ALLDocs – CE for Annual Meeting – Cancun, Mexico
		Alcon – Multifocal Road Show – Jacksonville, FL
		Alcon – Multifocal Road Show – Lake City, FL
	- Dec	Alcon – Multifocal Road Show – Daytona Beach, FL
2017	**- Jan**	Rhode Island Optometric Association – CE Presentations
		Alcon – NSM Presentation – San Antonio, TX
	- Mar	Vision Expo East – CE Presentations – New York, NY
		Practices of Distinction-Strive to Thrive 2017 – New York, NY
		Carl Zeiss Meditec – Presentation – New York, NY
	- Apr	Pinellas County Optometric Association – CE Presentations – Clearwater, FL
	- May	Vision Source Exchange 2017 – CE Presentations – Nashville, TN
	- Jun	Practices of Distinction-Strive to Thrive 2017 – Boston, MA
		Eyefinity Education Conference – Speaker – Boston, MA
		Practices of Distinction-Strive to Thrive 2017 – West Palm Beach, FL
		AOA – CE Presentations – Washington DC
	- Jul	Allergan Restasis Presentation – Miami, FL
		Allergan Restasis Presentation – West Palm Beach, FL
		Zeiss: Building Your Practice with OCT & FORUM Simulcast – Miami, FL
	- Aug	Allergan Restasis Presentation – Anchorage, AK
	- Oct	Indiana Optometric Association – CE Presentations – Bloomington, IN
		AAO – CE Presentations – Chicago, IL
		FT Worth Fall CE – CE Presentations – Fort Worth, TX
		Practices of Distinction-Strive to Thrive 2017 – Pala Mesa, CA
		Practices of Distinction-Strive to Thrive 2017 – Anaheim, CA
		Ocusoft Presentation – Miami, FL
		Allergan Restasis Presentation – Orlando, FL
	- Nov	Alcon Presentation – Atlanta, GA
		Arizona Optometric Association – CE Presentations – Sedona, AZ
		Allergan Restasis Presentation – Jacksonville, FL
		Allergan Restasis Presentation – Winter Haven, FL
		Allergan Restasis Presentation – Memphis, TN
		Allergan Restasis Presentation – Nashville, TN
2016	**- Jan**	NEFOS – CE Presentation - Jacksonville, FL
		Practices of Distinction – Marietta, GA
	- Feb	Prima – Profiting with Vision Plans - CE Presentation
	- Mar	Alcon - Multifocal Contact Lens Presentation – Honolulu, HI
		Vision Source Exchange – CE Presentations – San Antonio, TX
		University of Houston, College of Optometry – CE Presentations
	- Apr	Vision Expo East – CE & COR Presentations – New York, NY
		WFOA – CE Presentations – Pensacola, FL
	- Jun	Destination Distinctive Practice – Chattanooga, TN
		Motivation Based Interviewing Seminar – Chattanooga, TN
	- Jul	Destination Distinctive Practice – San Diego, CA
		Destination Distinctive Practice – Anaheim, CA
	- Aug	SWFOA – CE Presentations – Captiva Island, FL
		Allergan Eye Care Innovation Summit – Irvine, CA
		Alcon Academy for Eye Care Excellence – Ft. Worth, TX

- **Sept** Destination Distinctive Practice – Phoenix, AZ
  Vision Expo West – CE & COR Presentations – Las Vegas, NV
  Destination Distinctive Practice – West Palm Beach, FL
- **Oct** Destination Distinctive Practice – Portland, OR
- **Nov** American Academy of Optometry – CE Presentations – Anaheim, CA
  Manasota County Optometric Association – CE Presentation
  Destination Distinctive Practice – Burlington, MA

2015
- **Feb** Palm Beach Winter Seminar – CE Presentations
  Practices of Distinction Tour – West Palm Beach, FL
  Allergan – Restasis Presentation
  Practices of Distinction Tour – Honolulu, HI
  Allergan – Restasis Presentation
  Hire Authority Seminar – New Orleans
  Practices of Distinction Tour – Indianapolis, IN
  Allergan – Restasis Presentation
- **Mar** Vision Expo East - CE & COR Presentations – New York, NY
  Practices of Distinction Tour – Nashville, TN
  Allergan – Restasis Presentation
  Oklahoma Optometric Association – CE Presentations
- **Apr** Vision Source Exchange 2015, Phoenix, AZ
  - CE Presentations
  - Zeiss Academy Presentation & Main Stage Presentation
- **May** Practices of Distinction Tour – Lafayette, LA
  Allergan – Restasis Presentation
  Practices of Distinction Tour – Howell, MI
  Allergan – Restasis Presentation
  Practices of Distinction Tour – Portland, OR
  Allergan – Restasis Presentation
- **June** Alcon – Multifocal Contact Lens Presentation – Atlanta, GA
  Practices of Distinction Tour – Dallas, TX
  Allergan – Restasis Presentation
  Practices of Distinction Tour – Spokane, WA
  Allergan – Restasis Presentation
  American Optometric Association – CE Presentations
  University of Houston, College of Optometry – CE Presentations
- **July** Florida Optometric Association – CE Presentations
  Practices of Distinction Tour – San Diego, CA
  Allergan – Restasis Presentation
  Practices of Distinction Tour – Los Angeles, CA
  Allergan – Restasis Presentation
- **Aug** Essilor Labs of America – National Sales Meeting Presentation – Dallas, TX
  North East Florida Optometric Society – CE Presentation
- **Sept** Great Western Council of Optometry – Portland, OR
  - Keynote Presentation
  - 8 Hours of CE Presentations

  Vision Expo West – Las Vegas, NV
  - Air Optix Colors Studio – Live Event
  - Women in Optometry Presentation
  - CE Presentations

- **Oct** Practices of Distinction Tour – San Antonio, TX
  Allergan – Restasis Presentation
  East West Eye Conference – CE Presentations
  American Academy of Optometry – CE Presentations
  Practices of Distinction Tour – Berkeley, CA
  Allergan – Restasis Presentation
  Practices of Distinction Tour – Fresno, CA
  Allergan – Restasis Presentation
  University of Houston, College of Optometry – CE Presentations
  Practices of Distinction Tour – Phoenix, AZ
  Allergan – Restasis Presentation
  Practices of Distinction Tour – Seattle, WA
  Allergan – Restasis Presentation – Seattle, WA
  Allergan – Restasis Dinner Presentation – Tacoma, WA
- **Nov** Practices of Distinction Tour – Williamsburg, VA
  Allergan – Restasis Presentation
  Avenova – Co-Presenter, Dinner Presentation – Williamsburg, VA
  New Jersey Society of Optometric Physicians – CE Presentations

2014
- **Jan** Alcon – Dailies Total 1 Presentation, Norfolk, VA
  Alcon – Problem Based Learning, Norfolk, VA
- **Feb** Alcon – Dailies Total 1 Presentation, Honolulu, HI
  Vision Source – Practices of Distinction, Honolulu, HI
- **Mar** SECO 2014, Atlanta, GA
  Alcon – Problem Based Learning, Rogers, AR
  Alcon – Dailies Total 1 Presentation, Rogers, AR
  Alcon – Dailies Total 1 Presentation, Jacksonville, FL
  Alcon – Problem Based Learning, Jacksonville, FL
  AOA – 3rd Party Presentation, Orlando, FL
  NEFOS 2014 – CE Co-Presenter with Dr. Carl Spear, Jacksonville, FL
  Vision Expo East 2014 – CE Presentations
  Vision Source – Practices of Distinction
  Vision Expo East 2014, New York, NY
- **April** Alcon – Dailies Total 1 Presentation, Atlanta, GA
  Alcon – Dailies Total 1 Factory Presentation, Johns Creek, GA
  Vision Source Exchange 2014 – Carl Zeiss Meditec main stage Presentation
  Alcon – Dailies Total 1 Presentation, Orlando, FL
  Alcon – Problem Based Learning, Orlando, FL
  Miami Nice 2014 – CE Presentation, Miami, FL
  Alcon – Women's Advisory Board, Dallas, Texas
- **May** VSP – Advisory Board, Montreal, Canada
  Vision Source – Practices of Distinction
    - Miami, FL
    - Raleigh, NC
    - Nashville, TN
    - Atlanta, GA
  Alcon – Dailies Total 1 Presentation, Norfolk, VA
  Alcon – Problem Based Learning, Washington DC
- **June** Alcon – Problem Based Learning, Hagerstown, MD
  Alcon – Dailies Total 1 Presentation, Tysons Corner, VA

VSP – Student Leadership Conference, Columbus, OH
Allergan – Restasis Presentation, Bonita Springs, FL
Vision Source Alabama CE Meeting
American Optometric Association – CE Presentation
Women in Optometry Presentation, AOA, Philadelphia

- July Vision Source – Practices of Distinction
- Brighton, MI
- Columbus, OH
- Indianapolis, IN
- Bloomington, IL

Florida Optometric Association 2014, Boca Raton, FL

- Aug Vision Source – Practices of Distinction
- Green Bay, WI
- San Diego, CA
- Los Angeles, CA

South Seas Optometric Conference, Captiva Island, FL
Allergan – Restasis Presentation, West Palm Beach, FL
Alcon – Dailies Total 1 Presentation, Anchorage, AK
Allergan – Restasis Presentation, Anchorage, AK
Vision Source – Administrator Advisory Board Meeting, Houston, TX

- Sept Rhode Island Optometric Association, CE Presentation
Vision Expo West 2014
- CE Co-Presenter with Dr. Dori Carlson
- Allergan – Global Contact Lens Forum
- Alcon – COR Women in Optometry Presentation

Vision Source – Practices of Distinction
- Seattle, WA
- Las Vegas, NV
- Dallas, TX
- Tulsa, OK

- Oct Alcon – Colors & Dailies Total 1 Presentation, Nashville, TN
Vision Source – Practices of Distinction
- Denver, CO
- Boston, MA
- Modesto, CA

- Nov Vision Source – Practices of Distinction
- Fredericksburg, VA

American Academy of Optometry 2014, Denver, CO
- Armed Forces Optometric Society CE Presentation
- Academy CE Co-Presenter with Dr. Carl Spear
- Alcon – Alcon Innovations Presentation
- Women in Optometry Presentation
- Women of Vision/VIEW Program – Speaker Panel

2013 - Jan Leadership OD - Executive Retreat, Foxhall, Georgia
- Feb Texas Optometric Association, Austin, Texas

- Mar SECO 2013, Atlanta, Georgia
Alcon – Problem Based Learning, Orlando, FL

Alcon – Dailies Total 1 Presentation, Springfield, MO
Alcon – PDC Travel, Rogers, AR
Alcon – Dailies Total 1 Presentation, Rogers, AR
Vision Expo East, New York, NY

- April Alcon – PDC Travel, MO
Alcon – Dailies Total 1 Presentation, MO
Alcon – PDC Travel, KS
Alcon – Dailies Total 1 Presentation, KS
Alcon – Dailies Total 1 Stage Presentation at Vision Source North American Meeting
Marco – Main Stage Presentation at Vision Source North American Meeting

- May Mountain West Council of Optometrists, Las Vegas, NV
Alcon – Dailies Total 1 Breakfast Symposium, Las Vegas, NV
Alcon – Problem Based Learning, Orlando, FL
Alcon – PDC Travel, KS
Alcon – Dailies Total 1 Presentation, KS
Alcon – Dailies Total 1 US Launch Presentations, Dallas, TX

- June Alcon – Dailies Total 1 Breakfast Symposium, LA
Alcon – Dailies Total 1 Presentation, Ft. Lauderdale, FL
Alcon – PDC Travel, Phoenix, AZ
Alcon – Dailies Total 1 Presentation, Phoenix, AZ
Alcon – PDC Travel, Tucson, AZ
Alcon – Dailies Total 1 Presentation, Tucson, AZ
Alcon – Dailies Total 1 Presentation, Orlando, FL
AOA – Alcon – Dailies Total 1 Lunch Symposium, San Diego, CA

- July Alcon – Dailies Total 1 Presentation, Melbourne, FL
Alcon – Dailies Total 1 Presentation, Atlanta, GA
Alcon – PDC Travel, Atlanta, GA
Alcon – Dailies Total 1 Presentation, MD
Alcon – PDC Travel, Washington DC
Alcon – Dailies Total 1 Presentation, Washington DC

- Aug Alcon – Dailies Total 1 Breakfast Symposium, Captiva Island, FL
South Seas Optometric Conference, Captiva Island, FL
Alcon – Dailies Total 1 Presentation, Atlanta, GA
Alcon – PDC Travel, Columbus, OH
Alcon – Dailies Total 1 Presentation, Columbus, OH
Alcon – PDC Travel, Springfield, MO
Alcon – Dailies Total 1 Presentation, Springfield, MO
Alcon – PDC Travel, Rogers, AR
Alcon – Dailies Total 1 Presentation, Rogers, AR
Alcon – PDC Travel, Richmond, VA
Alcon – Dailies Total 1 Presentation, Richmond, VA
Alcon – PDC Travel, Norfolk, VA
Alcon – Dailies Total 1 Presentation, Norfolk, VA
Alcon – Dailies Total 1 Presentation, Daytona Beach, FL
Alcon – PDC Travel, Jacksonville, FL
Alcon – Dailies Total 1 Presentation, Jacksonville, FL
Alcon – PDC Travel, Nashville, TN
Alcon – Dailies Total 1 Presentation, Nashville, TN
Nova Southeastern University Student Presentation, Davie, FL
Leadership OD, Executive Retreat, San Diego

- **Sept** Alcon – PDC Travel, Knoxville, TN
  Alcon – Dailies Total 1 Presentation, Knoxville, TN
  Alcon – PDC Travel, Minneapolis, MN
  Alcon – Dailies Total 1 Presentation, Minneapolis, MN
  Alcon – Dailies Total 1 Presentation, Waite Park, MN
  Alcon – PDC Travel, Annapolis, MD
  Alcon – Dailies Total 1 Presentation, Annapolis, MD
- **Oct** Vision Expo West – COR Presentation, Las Vegas, NV
  Academy of Optometry – Dailies Total 1 AAO Innovation Symposium, Seattle, WA
- **Nov** Alcon – Dailies Total 1 Presentation, Ft. Lauderdale, FL
  Alcon – Dailies Total 1 Presentation, Orlando, FL
  Optometry Times Webinar – Strategies to create a contact lens practice of distinction with daily disposables
  Tennessee Vision Source Annual State Meeting – Top 5 Practice Management Lessons of 2013
  Brevard Optometric Association – Practicing Optometry: Understanding the Present, Anticipating the Future
  Alcon – Dailies Total 1 Presentation, Melbourne, FL
- **Dec** Creating Practices of Distinction, Manchester, NH
  Alcon – Problem Based Learning, Orlando, FL
  Alcon – Dailies Total 1 Presentation, Springfield, MO
  Alcon – PDC Travel, Springfield, MO

2012
- **Feb** Minnesota Optometric Association, Minneapolis, MN
  Brevard Optometric Association, Stuart, Florida
  OfficeMate/Eyefinity Educational Event, Orlando, Florida
- **April** Vision Source Student OD Symposium with VSP/Allergan, Orlando, Florida
  Alcon – Problem Based Learning, Memphis, TN
- **May** OfficeMate/VSP Educational Event, Houston, Texas
  Alcon – Problem Based Learning, Ft. Lauderdale, FL
  Alcon – Problem Based Learning, Miami, FL
  Alcon – Problem Based Learning, Ft. Lauderdale, FL
  Alcon – Pure Moist Presentation, Orlando, FL
  Alcon – Pure Moist Presentation, Boca Raton, FL
  Nova Southeastern University Student Presentation, Davie, FL
- **June** Alcon – Problem Based Learning, Ft. Lauderdale, FL
  Alcon – Problem Based Learning, Boca Raton, FL
  Alcon – Problem Based Learning, Ocala, FL
- **July** Florida Optometric Association, Miami, Florida
  Alcon – Problem Based Learning, Miami, FL
- **Aug** South Seas Optometric Conference, Captiva, Florida
  Nova Southeastern University Student Presentation, Davie, FL
- **Sept** FOA EHR Presentation, Florida
  Vision Source Facilitator Presentation
  Vision Expo West, Las Vegas, Nevada
  Rhode Island Optometric Association, Providence, RI
  Vision Source Minnesota, Minneapolis, MN
- **Oct** Nova Southeastern University Student Presentation, Davie, FL
  Alcon – Problem Based Learning

	- Nov	Alcon – Problem Based Learning FOA – RBD – 3rd Party Presentation CFSOP – CE Presentation – 3rd Party
	- Dec	Alcon – Problem Based Learning Alcon – Dailies Total 1 – Launch Video Shoot, New York, NY
2011	**- April**	Johnson & Johnson, The Vision Care Institute, Jacksonville, Florida OfficeMate/Eyefinity Educational Event, Orlando, Florida
	- May	Gator Vision, Gainesville, Florida Johnson & Johnson, The Vision Care Institute, Jacksonville, Florida
	- July	Johnson & Johnson, The Vision Care Institute, Jacksonville, Florida Florida Optometric Association, Orlando, Florida
	- Aug	Johnson & Johnson, The Vision Care Institute, Jacksonville, Florida South Seas Optometric Conference, Captiva, Florida
	- Sept	Johnson & Johnson, The Vision Care Institute, Jacksonville, Florida Imhoff Summer Seminar, St. Simons Island, Georgia Vision Expo West, Las Vegas, Nevada
	- Oct	Johnson & Johnson, The Vision Care Institute, Jacksonville, Florida
	- Nov	Johnson & Johnson, The Vision Care Institute, Jacksonville, Florida
	- Dec	Johnson & Johnson, The Vision Care Institute, Jacksonville, Florida
2010	**- Mar**	The Optometric Student Practice Management Symposium
	- April	Kentucky Optometric Association, Louisville, Kentucky
	- June	American Optometric Association, Orlando, Florida
	- July	Colorado Vision Summit, Steamboat Springs, Colorado
	- Aug	South Seas Optometric Conference, Captiva Island, Florida
	- Sept	Imhoff Summer Seminar, St. Simons Island, Georgia
	- Oct	Broward County Optometric Association, Ft. Lauderdale, Florida
	- Nov	Dade County Optometric Association, Miami, Florida Optometric Practice Management Symposium, Orlando, Florida
2009	**- June**	American Optometric Association, Washington DC OfficeMate & ExamWriter Training, Atlanta, Georgia

RESEARCH/STUDY EXPERIENCE

2019 - Alcon, Ft Worth, TX
Clinical Site for contact lens study
- Principal Investigator
- Selected and Trained Study Coordinator

2018 - Alcon, Ft Worth, TX
Clinical Site for contact lens study
- Principal Investigator
- Selected and Trained Study Coordinator

2014 - Vistakon, Jacksonville, FL
Clinical Site for contact lens study
- Principal Investigator
- Selected and Trained Study Coordinator

2013 - Alcon, Ft Worth, TX
Clinical Site for contact lens study
- Principal Investigator

- Selected and Trained Study Coordinator

2012 - Alcon, Ft Worth, TX

Clinical Site for contact lens study

- Principal Investigator
- Selected and Trained Study Coordinator

2012 - Alcon, Ft Worth, TX

Clinical Site for contact lens study

- Principal Investigator
- Selected and Trained Study Coordinator

CONGRESS PRESENTATIONS

AMCP

- Johnston J, Karpecki P, Kannarr S, Shen Lee B, Varghese G, Lowry S, Jasper A, Devries DK. Effect of OTX-101, a novel nanomicellar cyclosporine formulation, on total conjunctival staining score. Poster presented at: Academy of Managed Care Pharmacy; 2019 Mar 25-28; San Diego, CA.

AAO Optom

- Johnston J, Karpecki P, Kannarr S, Shen Lee B, Varghese G, Lowry S, Jasper A, Devries DK. Effect of OTX-101, a novel nanomicellar cyclosporine formulation, on total conjunctival staining score. Presented at: American Academy of Optometry; 2018 Nov 7-10; San Antonio, TX.
- Karpecki P, Evans D, Johnston J, Jasper A, Justice A, Devries D. Pharmacokinetics of OTX-101 in New Zealand white rabbits and healthy volunteers. Poster presented at: American Academy of Optometry; 2018 Nov 7-10; San Antonio, TX.

MANUSCRIPTS IN PROGRESS

- Smyth-Medina R, Johnston J, Devries DK, Jasper A, Kannarr SR, Schechter AR, Shen Lee B, Varghese G, Ogundele A, Darby CH, Karpecki P, Luchs J. Effect of OTX-101, a novel nanomicellar formulation of cyclosporine A, on conjunctival staining in patients with keratoconjunctivitis sicca: a pooled analysis of phase 2b/3 and 3 clinical trials. *Journal of Ocular Pharmacology and Therapeutics.*

DISTINCTIVE PROJECTS/CONSULTATION:

2016 Distinctive Strategies & Leadership – Destination Distinctive Practice Tour – 10 Location Full-Day Practice Management Seminar offered as a follow up to the 2015 Practices of Distinction Tour.

2015 Distinctive Strategies & Leadership – Practices of Distinction Tour – 20 US Location Full-Day Practice Management Seminar offered as a follow up to the 2014 Practices of Distinction Tour.

2014 Vision Source – Practices of Distinction Tour – 21 US Location Tour presenting 3 Hour CE Practice Management Course geared toward helping Doctors create Practices of Distinction.

Alcon – Presented Dailies Total1 at 6 strategic meetings including the US Launch of Dailies Total1 in Dallas, American Optometric Association in San Diego, American Academy of Optometry Innovation Symposium in Seattle and 2013 Vision Source North American Meeting in Las Vegas.

Alcon – Personal story was used at the US Sales Launch

Alcon – Conducted 32 dinner meetings in 2013 through Speakers Alliance (27 for Dailies

Total1 and 5 Problem Based Learning Dinners for Air Optix Multifocal)
Alcon – 1 of 15 Key Opinion Leaders that helped lay the groundwork for Dailies Total1 Strategy/Messaging receiving one of the first fitting sets in the US

ACTIVITIES/ASSOCIATIONS

CURRENT:

American Academy of Optometry, Chair of Corporate Relations Committee
2018 – Present
Florida Optometric Association, Currently serving as Co-Chair Corporate Relations
2009 – Present
Shire Advisory Board
Allergan Advisory Board
Florida Optometric Association, Member
American Optometric Association, Member
Lighthouse For The Blind, Board Member 2010 - Current
Alcon Speakers Bureau
Marco Ophthalmics, Consultant
Konan Medical, Consultant
Solution Reach, Consultant
Eight to Eighty, Consultant
MacuHealth, Consultant
Optovue, Consultant
Carl Zeiss Meditec, Consultant and Speaker

PAST:

American Academy of Optometry, Member, Communications Committee
2014 - 2018
Vision Source – Administrator Advisory Board
Alcon Dry Eye Advisory Board
Alcon Dailies Total1 Advisory Board
Alcon Dailies Brand Advisory Board
Lacrisert Advisory Board
Eyefinity/VSP Advisory Board
ExamWriter Advisory Board
Acuvue 1-Day Advisory Board
Florida Optometric Association, Director - Ophthalmic Professionals Committee
American Optometric Association, Member Third Party Center Executive Committee
NW Florida Optometric Association, President 2000 - 2002
Sunshine Eyecare Alliance, Board Member 2004 - 2006

PUBLICATIONS:

Optometric Management, Chief Optometric Editor, Oct. 2018 - Present

2016 – 2018 **Women in Optometry, Professional Co-Editor**

Contact Lens Spectrum, Cosmetic Fitting Tip of the Month, 2015 - 2017
- Opportunity Is Knocking
- Start Spreading the News
- Starting the Conversation
- Introduce Colored Lenses to All Patients
- Streamline the Color Selection Process

- Creating the Try-On Experience
- Color Lenses Not Available in Her Prescription…Now What?
- Staff Training: Streamlining Color Choices
- Creating a Beauty and Wellness Center
- Utilizing Contact Lens Vendor Rebates and Promotions
- Success Depends On Teamwork
- Lifetime Value of Our Cosmetic Contact Lens Patients
- The Story
- Don't Miss a Beat - Or an Opportunity
- Fun with Colors
- Tell Your Story in the Community and at Local Businesses

Optometric Management, Technology Section, 2013 - 2014

- Top of the Charts: A discussion on the numerous benefits of corneal topography
- Worth a Thousand Words: Understand the benefits of Anterior Segment Photography
- Measuring Up: Consider the benefits of measuring devices to aid custom lens sales
- A Judgment Call: Determine which recall phone system meets your needs
- Gathering Intelligence: Use business intelligence to evaluate your practice
- Effectively Manage Patients: Retain and attract patients by using contact management systems
- Like Clockwork: High-tech time keeping devices increases office efficiency
- New Ways to Reach Patients: Distinguish your practice through high-tech merchandising strategies
- It's All In What You Say
- From Low to High Tech
- Develop A Tech Game Plan: Stick to your practice's fundamentals to ensure successful implementation
- The What, When and How of Buying Technology
- My Innovation Wish List
- Making the Connection: Your EHR must "Talk" with other healthcare technology
- Technology in the Dispensary
- Six Technologies for Dry Eye
- Considering the Cloud?
- Meaningful Use Update
- A Future in Three Dimensions
- Create a Practice of Distinction: Six steps to standing out from the crowd
- Averting Audits: Part 1 – Questions you must ask to avoid a third party audit
- Averting Audits: Part 2 – How to ensure your EHR doesn't place you at risk for a billing review
- Averting Audits: Part 3 – Compliance programs can prevent a CMS billing review or help your case
- Color Contact Lenses: Specialized Lenses enable patients to change their look
- Choosing and Using Technology: A look at when to purchase and utilize technology

Optometric Management

- Patient Testimonials: Your Best Advertisement
- The Purchase Tipping Point: Eyeglasses Warranty
- Doctor Patient Communication Starters: Keys to Stellar Service
- Ortho-K: Please Patients and Build Your Practice

- Use Electronic Health Records to enhance Patient Experience
- Deliver Great Service with Staff Policies Based on Your Mission Statement
- Plan How You Shop for New Office Space

- It's All in What You Say: These 10 rules can help you create effective communications that impact your patients/customers
- Capture Cost Savings with Electronic Health Records
- Can You Lower Accounts Receivable While Promoting Patient Loyalty?
- Should You Add "Wellness" to Your Practice?
- How EHR Can Impact Your Marketing Program
- EMR: Good For Your Patients And Good For You
- Loyalty: Why Doing Nothing Is Your Worst Option
- Loyalty: Essential Elements Of Patient Loyalty
- Loyalty: How To Create Loyalty In Your Practice
- How To Manage Patients When Systemic Medications Affect Vision

eyetubeOD
- Business in Optometry, AAO, 2014
- DED: You Are the Expert, AOA, 2013

Optometric Office
- Boosting Your Practice with Pediatric-Friendly Instruments
- Creating an Exam Lane That "Wows"

MBA Insights – 2nd Quarter 2012
- MBA Ideas Provide Focus for Practice Growth

Vision Care Professional
- Addressing Presbyopic Needs with Multifocal Contact Lenses

HONORS/AWARDS:

Florida Optometric Association – 2019 Optometrist of the Year
Vision Source Administrator – 2016 Best Net Promoter Score
Vision Monday – Influential Women in Optical – November 2014
Vision Monday – Optometric Business Innovators of 2013 – June 2013
Vision Source – New Administrator of the Year 2009
Graduated with Highest Honors, Doctor of Optometry
Beta Sigma Kappa
President's List
Dean's List

CHARITABLE INVOLVEMENT:

Lighthouse For The Blind
Rotary International – Numerous Charitable Functions
Jeppesen Vision Quest
Community Health Fairs
Lions Club

STATE OF FLORIDA BOARD OF OPTICIANRY

NOTICE OF MEETING

TO: **Florida Optometric Association**
120 South Monroe Street
Tallahassee, Florida 32301

PLEASE TAKE NOTICE that CE Broker course #20-779946, "Creating Your Practice of Distinction", is on the October 23, 2020 agenda for review by the Board of Opticianry. The meeting is scheduled to begin at 9:00 A.M., EST via teleconference call. The dial-in information is:

Dial-in #: 1 (888) 585-9008 Participation Code: 123-475-828 #

You are not required to appear at this meeting. However, you are encouraged to attend. It may be helpful for you to appear in the event the Board has any questions concerning this review.

This is a public meeting and participants in this public meeting should be aware that these proceedings are being recorded and that an audio file of the meeting will be posted to the board's website.

CERTIFICATE OF SERVICE

I, HEREBY CERTIFY that a true and correct copy of the above and foregoing Notice of Meeting has been sent by U.S. Mail to the above address on this September 25, 2020.

Eric Pottschmidt
Program Operations Administrator
Email: Eric.Pottschmidt@flhealth.gov
Phone: (850) 245-4292, Facsimile: (850) 413-6982
4052 Bald Cypress Way, Bin # C08
Tallahassee, Florida 32399-3258

Course Summary

FOCAL EDUCATION LLC.

Course # 20 - 790716 – Lens Manufacturing, Past, Present and Future

CE Committee Review Comments:

Board Review Required.

Course Addition Request	
Course Name	Lens Manufacturing, Past, Present and Future Video Presentation Home Study
CE Broker Course Tracking #	20 - 790716
Course Description	Introduce the lens production process with variations to help the Opticians better communicate the process with their Patients. The Opticians will learn the sequence of events when it relates to the lens creation. The Optician will learn the data entry process which is where it all begins then on to lens design, surfacing, coatings, generator, polishing, edging, and much more. This an incredibly detailed comprehensive course that will offer insight to the new innovative technology of today in lens manufacturing with the newest and latest lens designs. Learning Goals: 1. Be able to differentiate between Traditional and Digital surfacing 2. Begin relating the surfacing process with specific lens benefits 3. Make connections with lens production process to the time frame required to receive an order 4. Become familiar with terms associated with lens production to be able to give Patients informed updates with their order. 5. Be introduced to the lab edging process on a high level and relate to in house optical labs. Introduce the lens production process with variations to help the Opticians better communicate the process with their Patients. The Opticians will learn the sequence of events when it relates to the lens creation. The Optician will learn the data entry process which is where it all begins then on to lens design, surfacing, coatings, generator, polishing, edging, and much more. This an incredibly detailed comprehensive course that will offer insight to the new innovative technology of today in lens manufacturing with the newest and latest lens designs. Learning Goals: 1. Be able to differentiate between Traditional and Digital surfacing 2. Begin relating the surfacing process with specific lens benefits 3. Make connections with lens production process to the time frame required to receive an order 4. Become familiar with terms associated with lens production to be able to give Patients informed updates with their order. 5. Be introduced to the lab edging process on a high level and relate to in house optical labs. Purpose of Course: 1. Opticians have been introduced to many of the new lens solutions and designs available to their Patients. 2. Once a lens has been ordered, it is important for the Optician to have a high level of understanding of the lens production process 3. To create the best Patient Experience, the Optician should follow order updates through online portals or direct communications with the lab 4. It is necessary to be familiar with common lab terms to understand what step in the process the orders are in. Many Opticals will also have an in-house lab, so this will provide an introduction to the finishing the job.
Provider	FOCAL EDUCATION LLC.
Course Type	Anytime
Delivery Method	Prerecorded Broadcast
Provider Type	Board Approved Provider

Profession Selection + Hours	Renewal Hours	Approved Hours
Optician		
HIV/AIDS	0	
Medical Errors	0	
Technical Practice	1	
Elective	0	
Technical Practice (Contact Lens Theory and Practice)	0	
Laws and Rules of the Board (Initial Licensure or Renewal)	0	
Laws and Rules of the Board (Renewal Only, not for Initial Licensure)	0	
Laws and Rules of the Board (Apprentice Orientation)	0	
20-hour Board Certification Course (not taken to obtain Board Certification)	0	

John Zimmerman
Senior Retail Business Development Representative for Carl Zeiss Vision Care Business Group

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Lens Manufacturing: Past, Present, & Future…Virtual Conference Video
Outline Summary with Timeline

Production Basics: 10 Minutes

A. Overview

B. Waste in production

Traditional Lens Manufacturing: 10 Minutes

A. Lacks a clean environment

B. Expensive to maintain

C. Too much Inventory is required

Digital Surfacing: 10 Minutes

A. Data entry

B. Blocking

C. Less Inventory

D. Pucks

Coatings & Treatments: 10 Minutes

A. Hard Coats

B. Anti-Reflective

C. Tinting

D. Photo Chromatics

Finishing: 10 Minutes

A. Spot/Block

B. Edging

C. Touch Off

D. Edge Polish

E. Drill Mount

F. Assembly

G. Power Verify and Inspections

H. Pack & Ship

Questions and Answers Approximately 10 Minutes

Questions

Title:	Lens Manufacturing, Past, Present and Future
Topic:	Take A Virtual Tour on the process of lens manufacturing from the very beginning of conception to the birth of the lens.
Objective:	Introduce the lens production process with variations to help the Opticians better communicate the process with their Patients…The Opticians will learn the sequence of events when it relates to the lens creation…The Optician will learn the data entry process which is where it all begins then on to lens design, surfacing, coatings, generator, polishing, edging, and much more. This an incredibly detailed comprehensive course that will offer insight to the new innovative technology of today in lens manufacturing with the newest and latest lens designs. Learning Goals: • Be able to differentiate between Traditional and Digital surfacing • Begin relating the surfacing process with specific lens benefits • Make connections with lens production process to the time frame required to receive an order • Become familiar with terms associated with lens production to be able to give Patients informed updates with their order. • Be introduced to the lab edging process on a high level and relate to in house optical labs. Purpose of Course: • Opticians have been introduced to many of the new lens solutions and designs available to their Patients.

	• Once a lens has been ordered, it is important for the Optician to have a high level of understanding of the lens production process • To create the best Patient Experience, the Optician should follow order updates through online portals or direct communications with the lab • It is necessary to be familiar with common lab terms to understand what step in the process the orders are in. Many Optica's will also have an in-house lab, so this will provide an introduction to the finishing the job
Question: 1 **Answer: D**	The Optical World has been going through massive changes in the manufacturing of lenses since_____ A) 1980 B) 1970 C) 1990 D) 2000
Question: 2 **Answer: A**	The current "Big" change that we are in when it comes to new lens technology, designs, and the entire lens production process will Continue for the next_____ A) 20 years and we are right in the middle of this change B) 5 years and we are right at the end of this change C) 30 years and we are at the very beginning of this change
Question: 3 **Answer: B**	The process of lens manufacturing is incredibly unique and is not the same as any other type of product manufacturing. A) True B) False
Question: 4 **Answer: B**	• It is messy • It is expensive to maintain

	• Too much inventory is required The above bullet points relate to what type of surfacing. A) Modern Surfacing B) Traditional Surfacing C) The future of surfacing D) None of the above
Question: 5 **Answer: A**	Traditional lens surfacing was designed to create .25 diopter step Prescriptions A) True B) False
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Question: 9 **Answer: B**	• Transport • Inventory • Motion • Waiting • Over Production • Over Processing • Defects • Skills The above Are all considered what? A) 8 Profitable aspects of Lens manufacturing B) 8 types of waste in Lens Manufacturing C) None of the above
Question: 10 **Answer: B**	With New Modern Lens Production one of the customizations is designing the lens around the shape and dimensions of what? A) Patient's eye shape B) Frame C) None of the above

Lens Manufacturing, Past, Present and Future
Home Study Course Completion

FOCAL Education

P.O. Box 10383 Largo, FL 33773
Phone 727-687-6140 Fax 727-524-3625
Provider # 50-5300

Congratulations

This is to confirm that _____License #_____
has successfully completed the 1 hour **Lens Manufacturing, Past, Present and Future** Course on _____. Course # _____.
Not an ABO approved course

Licensee Signature_____
It is the licensee's responsibility to retain a copy of this certificate for proof of completion for future auditing purpose.
Course completion will be reported to CE Broker by FOCAL Education if you have a license number.

AUTOMATICALLY REPORTS CE TO CE BROKER

FOCAL Education Home Study Course Evaluation

1. How would you rate the course? Great, Good, Fair, Poor

2. How well were you educated? Great, Good, Fair, Poor

3. Do you have a better understanding of the subject? Yes or No

Please circle your answers to the above questions.

Name:

Phone#:

License#:

Date Completed:

STATE OF FLORIDA BOARD OF OPTICIANRY

NOTICE OF MEETING

TO: **Focal Education, LLC**
P.O. Box 10383
Largo, Florida 33773

PLEASE TAKE NOTICE that CE Broker course #20-790716, "Lens Manufacturing, Past, Present and Future Video Presentation Home Study", is on the October 23, 2020 agenda for review by the Board of Opticianry. The meeting is scheduled to begin at 9:00 A.M., EST via teleconference call. The dial-in information is:

Dial-in #: 1 (888) 585-9008 Participation Code: 123-475-828 #

You are not required to appear at this meeting. However, you are encouraged to attend. It may be helpful for you to appear in the event the Board has any questions concerning this review.

This is a public meeting and participants in this public meeting should be aware that these proceedings are being recorded and that an audio file of the meeting will be posted to the board's website.

CERTIFICATE OF SERVICE

I, HEREBY CERTIFY that a true and correct copy of the above and foregoing Notice of Meeting has been sent by U.S. Mail to the above address on this September 25, 2020.

Eric Pottschmidt
Program Operations Administrator
Email: Eric.Pottschmidt@flhealth.gov
Phone: (850) 245-4292, Facsimile: (850) 413-6982
4052 Bald Cypress Way, Bin # C08
Tallahassee, Florida 32399-3258

STATE OF FLORIDA BOARD OF OPTICIANRY

NOTICE OF MEETING

TO: **Focal Education, LLC**
960 Starkey Road
#2504
Largo, Florida 33771

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Tallahassee, Florida 32399-3258

Course Summary

FOCAL EDUCATION LLC.

Course # 20 - 787204 – Modern Optical Laboratory Production

CE Committee Review Comments:

Board Review Required. Freeform and digital processing are not synonymous. All freeform lenses are digitally processed but digitally processed lenses are not all freeform.

Course Addition Request	
Course Name	Modern Optical Laboratory Production Video Presentation Home Study
CE Broker Course Tracking #	20 - 787204
Course Description	Introduce the lens production process with variations to help the Opticians better communicate the process with their Patient. The Opticians will learn the sequence of events when it relates to the lens creation. The Optician will learn the data entry process which is where it all begins then on to lens design, surfacing, coatings, generator, polishing, edging, and much more. This an incredibly detailed comprehensive course that will offer insight to the new innovative technology of today in lens manufacturing with the newest and latest lens designs. Introduce the lens production process with variations to help the Opticians better communicate the process with their Patient. The Opticians will learn the sequence of events when it relates to the lens creation. The Optician will learn the data entry process which is where it all begins then on to lens design, surfacing, coatings, generator, polishing, edging, and much more. This an incredibly detailed comprehensive course that will offer insight to the new innovative technology of today in lens manufacturing with the newest and latest lens designs. Introduce the lens production process with variations to help the Opticians better communicate the process with their Patient. The Opticians will learn the sequence of events when it relates to the lens creation. The Optician will learn the data entry process which is where it all begins then on to lens design, surfacing, coatings, generator, polishing, edging, and much more. This an incredibly detailed comprehensive course that will offer insight to the new innovative technology of today in lens manufacturing with the newest and latest lens designs. Learning Goals 1.Be able to differentiate between Traditional and Digital surfacing 2.Begin relating the surfacing process with specific lens benefits 3.Make connections with lens production process to the timeframe required to receive an order 4.Become familiar with terms associated with lens production to be able to give Patients informed updates with their order. 5.Be introduced to the lab edging process on a high level and relate to in house optical labs. Purpose of Course 1.Opticians have been introduced to many of the new lens solutions and designs available to their Patients. 2.Once a lens has been ordered, it is important for the Optician to have a high level of understanding of the lens production process 3.To create the best Patient Experience, the Optician should follow order updates through online portals or direct communications with the lab 4.It is necessary to be familiar with common lab terms to understand what step in the process the orders are in. Many Optical's will also have an in-house lab, so this will provide an introduction to the finishing the job
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Modern Optical Lab Production

Carl Zeiss Vision – John Zimmerman

Lens Production

Lens Production- Introduction

Lens Production- Surfacing

Data entry

Most lens orders today, are delivered to the lab electronically. It will include a few pieces of key information. When the order arrives it will be assigned an order number. In large scales labs it will also be assigned a tray number. This tray number makes it easier to track the job as it moves through the process.

Other key information that is included:

- Patient name
- Prescription
- Lens Design
- Coatings and tints
- Uncut, cut or finished
- Edging/finishing specifications, such as bevel type and edge polish

Lens Production- Surfacing

Glossary of terms

- Surfacing: the process in which the curves required for a specific prescription are ground into the back side of the lens. There is a variety of methods that can be used for this task. The two most common methods today are freeform surfacing and, what is now referred to as, traditional surfacing.
- Generator: the piece of equipment that surfaces the prescription into the back side of the lens, freeform generators surface both the prescription and the lens design into the lens
- Polishing: The final step in surfacing the lens always includes polishing. Depending on the tools used to generate the lens the transparency will vary. At the end of the polishing process, the lens will be clear and ready to be cut, tinted, or coated.

Lens Production- Surfacing

Once the order is entered into the system, the correcting starting material needs to be pulled from inventory. It is important to distinguish between a few different starting points. Finished/stock lenses, semi-finished lenses and freeform pucks

- Finished/stock lenses: These lenses are pre-made within the most common range of patients' prescription. This can include spherocylindrical lenses. Most multifocals and higher single vision prescriptions, however, will fall outside of this range. They can even include tinted, photochromic, and AR coated lenses. They are ready to be cut and fit in a frame without additional steps. They are referred to as stock lenses as they can be stocked in an optical lab for immediate use.

Lens Production- Surfacing

- Semi-finished lenses: The front surface curve is specifically molded and in the case of progressive lenses, the design is molded on the front surface. The prescription is then surfaced on the back of the lens. After surfacing, they can be coated and tinted before being cut and finished.

Lens Production- Surfacing

- Freeform puck: Often referred to as pucks, because they resemble hockey pucks, or blanks, these lenses do not have a prescription or design molded into them. They are blank slates and require the use of specialized equipment to grind the prescription and design into the lens. These are the starting point for lenses that can be customized per the patient prescription, lifestyle needs, and fitting parameters.

- As these lenses are not pre-molded with engravings, before theses lenses are coated, they will receive customized laser engravings.

Lens Production- Surfacing

Blocking

Now that the proper starting material has been selected, the lens manufacturing can begin.
A lensometer is used to mark the optical center on the lens based on the patient's prescription, frame selection, and required lens design. The process of securing the lens in the proper position for the generator is called **blocking**. An adhesive layer is applied, taping, to protect the lens from the blocking materials. Once the lens has been taped a metal alloy is applied to bond the block to the lens. This requires a great deal of precision and is often done digitally now.
Before additional coatings are applied, the tape and block are removed.

Lens Production- Surfacing

Traditional surfacing with semi-finished lenses

Lens Production

Freeform/digital surfacing with freeform pucks

- Freeform is also often referred to as digital or direct surfacing
- The main feature is more accurate surfacing to provide clearer vision
- In some cases semi-finished lenses are surfaced using freeform generators for greater accuracy
- Dual-sided progressives have the design and part of the add power molded on the front and then are surfaced with a freeform generator

Lens Production

Freeform/digital surfacing with freeform pucks

- Advanced accuracy through Freeform Generators
    - Rotating diamond bits begin surfacing the back-side of a SV blank (both for SV and PALs)
    - A single, polycarbonate diamond bit pecks at the surface of the lens grinding in the optimized prescription point-by-point
    - Soft polishers uniquely polish each lens while preserving the optics

Lens Production

Freeform/digital surfacing with freeform pucks

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Lens Production- Coating (2 mins)

Photochromic

Photochromic lenses have the property to darken and clear based on the level of UV light present. There are several versions and manufacturers on the market that utilize different variations in application techniques and molecules. In general, application follows a similar theory.

- The application of a photochromic occurs before the lens is surfaced. If a self-tinting lens is ordered then the stock lens or puck pulled, must be photochromic.
- It is applied through one of two methods that is for the most part dependent on the lens material. In both cases, it is important to remember that the coating is bonded with the material and cannot peel off.
    - In the lens: This is possible with plastic (CR-39) and glass lenses. In this process the photochromic molecules are taken into the lens material.

Similar to staining a piece of wood. Hard coats and AR can then be layered on top.

- On the surface of the lens: The molecules are bonded to the surface of the lens material and a protective coating is layered on top. Hard coats and AR can then be layered on top as well.

Lens Production- Coating (2 mins)

Hard coat

Once the lens has been surfaced, they are meticulously cleaned. The coating room is kept almost completely free of dust and debris. The lenses must be equally clean or there will be flaws in the coating. Technicians will often wear gloves, hair nets, lab coats, shoe coverings and masks to prevent tracking in contaminants.

After cleaning a hard coat is applied. This will provide a base for tint and/or AR molecules to bond to. Dipping the lenses to apply the hard coat produces an even durable, double-sided coating.

Lens Production- Coating (2 mins)

Tinting

Tinting can be done with a variety of lens materials. Most opticals have the ability to tint lenses themselves, but large scale optical labs can provide a greater variety of colors with more consistency. Specific formulas of color are sometimes patented for specific purposes.

Things to remember:

- Timing and temperature is everything and is dependent on lens material
- Tinting is done prior to applying AR. This is very important for sunglass tint as the AR will make the lens more transparent and the tint appear lighter. It may be necessary to start with a shade darker if the lens will have AR.
- CR-39 and trivex have the best tinting properties
- Polycarbonate and most high index lenses are harder to tint, but the hard coat will provide a better surface for the tinting substrate

Lens Production- Coating (2 mins)

AR

Applying the anti-reflective coating is one of the most time-intensive portions of the lens production process. In most cases, the process takes a minimum of 24 hours.

AR application varies by lab equipment, formula, and purpose. The stack has to be applied in a specific order. The AR formula itself is composed of non-organic molecules, specifically metal-oxide molecules that improve the transmittance of light.

The AR can been detected on these lenses through the slight colored, metallic sheen on the surface of the lens.

Lens Production- Coating (2 mins)

AR- application

After the hard coat and any required tinting is applied the lenses are ready for AR application.

The layers of AR molecules are applied in a sealed vacuum chamber.

A rack of lenses rotates as the air is sucked out of the chamber and the metal-oxide AR formula is deposited on the lens.

An ion-assisted application involves a bombardment of electrons within the chamber to create a stronger, more even bond between the layers.

Lens Production

Spotting- Step 1: Prepping the Lensometer

1. Focus the eye piece on the lensometer – The *sphere* and *cylinder* lines should be clear and in the center of the reticle.
2. Make sure the power drum is placed on plano or zero
3. Adjust the lens table to accommodate the size of the lens

Lens Production

Spotting- Step 2: Marking the lens

Lens Production

Spotting- Step 3: Verifying power

Lens Production

Block- aligning the lens

Lens Production

Block- administering blocking

Lens Production

Edging

Edgers

Edgers come in many shapes and sizes. Large scale labs may utilize one of the following:

- Monosphera edger: edges one lens at a time
- Biosphera edger: edges two lenses at a time

Many in house optical labs keep a **tabletop edger** to fulfill basic prescriptions in a short time frame. These are very common in retail opticals. These devices are surprisingly dynamic for their small stature and in many cases are also used in larger finishing labs.

Regardless of the device, they all serve the same purpose, to receive frame shape and edging information in order to cut lenses.

Lens Production

Edging

The type of bevel on the edge of a lens is determined by the frame type, frame material and prescription. The bevel is used to secure the lens in the frame. Below are some examples of common bevels.

Side note:

- Drill mount (rimless) and semi-rimless frames may require the edges to be left thicker in order to have enough surface area to drill into the lens or to produce the groove for the nylon eye wire of semi-rimless frames.

Questions

Title:	Laboratory Production
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Modern Optical Laboratory Production Home Study Course Completion

FOCAL Education

P.O. Box 10383 Largo, FL 33773

Phone 727-687-6140 Fax 727-524-3625

Provider # 50-5300

Congratulations

This is to confirm that _____License #_____ has successfully completed the 1 hour **Modern Optical Laboratory Production** Course on _____. Course # _____. Not an ABO approved course

Licensee Signature_____

It is the licensee's responsibility to retain a copy of this certificate for proof of completion for future auditing purpose.

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FOCAL Education Home Study Course Evaluation

1. How would you rate the course? Great, Good, Fair, Poor

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3. Do you have a better understanding of the subject? Yes or No

Please circle your answers to the above questions.

Name:

Phone#:

License#:

Date Completed:

STATE OF FLORIDA BOARD OF OPTICIANRY

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Largo, Florida 33771

PLEASE TAKE NOTICE that CE Broker course #20-787204, "Modern Optical Laboratory Production Video Presentation Home Study", is on the October 23, 2020 agenda for review by the Board of Opticianry. The meeting is scheduled to begin at 9:00 A.M., EST via teleconference call. The dial-in information is:

Dial-in #: 1 (888) 585-9008 Participation Code: 123-475-828 #

You are not required to appear at this meeting. However, you are encouraged to attend. It may be helpful for you to appear in the event the Board has any questions concerning this review.

This is a public meeting and participants in this public meeting should be aware that these proceedings are being recorded and that an audio file of the meeting will be posted to the board's website.

CERTIFICATE OF SERVICE

I, HEREBY CERTIFY that a true and correct copy of the above and foregoing Notice of Meeting has been sent by U.S. Mail to the above address on this September 28, 2020.

Eric Pottschmidt
Program Operations Administrator
Email: Eric.Pottschmidt@flhealth.gov
Phone: (850) 245-4292, Facsimile: (850) 413-6982
4052 Bald Cypress Way, Bin # C08
Tallahassee, Florida 32399-3258

Course Summary

QUANTUM OPTICAL, INC

Course # 20 – 790260 – Field Guide to Freeform

CE Committee Review Comments:

Board Review Required.

Course Addition Request	
Course Name	Field Guide to Freeform
CE Broker Course Tracking #	20 - 790260
Course Description	Field Guide to Freeform
Provider	QUANTUM OPTICAL, INC
Course Type	Anytime
Delivery Method	Computer-Based Training (ie: online courses)
Provider Type	Board Approved Provider

Profession Selection + Hours	Renewal Hours	Approved Hours
Optician		
HIV/AIDS	0	
Medical Errors	0	
Technical Practice	1	
Elective	0	
Technical Practice (Contact Lens Theory and Practice)	0	
Laws and Rules of the Board (Initial Licensure or Renewal)	0	
Laws and Rules of the Board (Renewal Only, not for Initial Licensure)	0	
Laws and Rules of the Board (Apprentice Orientation)	0	
20-hour Board Certification Course (not taken to obtain Board Certification)	0	

Field Guide to Freeform

Level II Technical Course – 1 ABO credit hour

Written and presented by:
Jesse Walters, ABOM
ABO approved technical speaker

Course Description

Digital lens technology has forever changed the optical industry. It's important to understand how it works and what makes it better. Along with explaining advancements in customization and processing, I will also help guide you through proper fitting and effective patient communication.

Course Objectives

- Understanding of digital surfacing and how it effects lab production and lens capabilities
- Knowing what makes a lens design unique and how digital surfacing makes this possible
- Ability to take measurements and utilize customizations properly for your patient's unique visual needs

Outline

I. Introduction (5 minutes)
   - My credentials and experience
   - What is digital surfacing?
   - Precision and accuracy

II. Starting with a single vision blank (10 minutes)
   - Reducing lens stock with made to order designs
   - The potential for sophisticated design
   - Base curve optimization

III. What makes a progressive design better? (15 minutes)
   - Reducing higher order aberration with full backside design
   - The "key hole" effect
   - Position of wear measurements
   - Eye mover vs. head mover
   - Center rotation of the eye
   - Dual surface design
   - Using unique calculations per eye

IV. Taking measurements (10 minutes)

- POW measurements, why and when they are important
- Manual measurements
- Electronic measuring devices
- Corridor length customization
- Analysis of patient's visual needs
- Observation of frame fit and patient's head position

V. Single-vision HD (5 minutes)
- Benefits to the non-presbyope
- Optical center height

VI. Potential problems (5 minutes)
- Flaws and processing errors
- Alignment and fit
- Design changes

VII. Patient experience (5 minutes)
- Building value
- Sales strategy

VIII. Conclusion and Q & A (5 minutes)

JESSE WALTERS, ABOM

63 Blackhawk Drive, Livingston, MT 59047 | 406-224-1320 | jessestarrwalters@gmail.com

CERTIFICATIONS

ABO Qualified Technical Trainer Levels I, II and III	2012 – Present
ABO Master in Ophthalmic Optics	2012 – Present
ABO Advanced Certification	2010 – 2012
American Board of Opticianry Certified	2003 – 2010

TEACHING EXPERIENCE

Opticians Association of Oregon
Qualified Continuing Education Trainer for the OAO Spring Convention 2013, 2014
Compiled and lectured 6 hours of CE approved original coursework to optical professionals.

Montana Optometric Association
Qualified Continuing Education Trainer for the MOA Spring Convention 2013,2014
Lecturer for 4 hours of ABO accredited courses for Opticians and Para-optometric technicians.

Eye Central; Washington D.C.
Independent Consultant and Optical Trainer 2014
Assessed and streamlined processes involving lab ordering, pricing, insurance billing and use of electronic medical records.

Eyecare Professionals and Mountain Eyewear; Livingston, MT
Optician, ABOM 2013
Continued development of staff education lectures at weekly office meetings. Supported and sponsored as an ABO approved educator.

Eyes on Broadway; Portland, OR
Lab Manager 2012
Required to report on new lens technologies, fitting techniques, and proper lens ordering in a weekly opticians' meeting. Sponsored by the business to research, compose, and submit for approval ABO accredited coursework.

Carl Zeiss Vision; Clackamas, OR
Finish Department Lead and Trainer 2011
Conducted a daily production meeting for a staff of a dozen direct reports. Responsible for continual training and development of staff in lens finishing, equipment operation, frame handling, and safety concerns.

EMPLOYMENT HISTORY

Eyecare Professionals & Mountain Eyewear; Livingston, MT
Optician, ABOM January 2013 – Present

- Responsible for all verification of Rx and measurements of prescription eyewear.
- Analyze and troubleshoot with patient's whom experience adaptation difficulties.
- Assist with lens and frame solutions to best fit a patient's vision needs.
- Maintain lab supply ordering and invoice/credit monitoring.

Eyes on Broadway; Portland, OR
Lab Manager December 2003 – January 2013

- Responsible for all in house manufacturing of prescription eyewear.
- In charge of quality control of all completed eyewear. Requiring a very thorough examination of Rx, prism, measurements and adjustment.
- Assist patients with frame and lens selections as well as ordering the final product and billing vision insurance.
- Established and maintained the procedure for all lens, frame and contact lens credit return for warranty and defect.
- Conducted continuing education training for optical staff on new technologies and lens designs.

Carl Zeiss Vision; Clackamas, OR
Finishing Department Lead August 2011- March 2012

- Responsible for the operation, maintenance and calibration of all equipment and machinery including the MEI edging system.
- Direct a daily production meeting covering current production goals, process improvements, safety concerns and staffing adjustments.
- Perform root cause analysis on all non-conforming products and create training and process solutions to decrease breakage.
- Directly oversee more than dozen employees and responsible for hiring, training and continued development of personnel in tracing, blocking, edging, assembly, quality inspection, drill mounting, tint and repair.
- Continuously utilize the DVI computer system for tracking job status, breakage, shipping goals, stalled work and late order status.

Look Optical; Denver, CO
Lab Manger/ Dispensing Optician March 2003 – November 2003

- Edged lenses, ordered supplies, maintained uncut lens stock, and performed all duties pertaining to lab operations.
- Billed all insurance sales and filed all claims.
- Sold, fit and dispensed prescription eyewear.

PUBLICATIONS AND CIRRICULUM

"Unraveling the Compensated Prescription"
Technical Thesis for qualification of Master level certification in ophthalmic optics through the American Board of Opticianry

"The Bevel's Advocate"
ABO approved level I technical course, 2 ABO credit hours
Course Description:
Proper edge selection and lens finishing can really make or break the final product of any spectacle order. Knowing your options is only half the battle. This course will also explore the proper meanings of commonly misinterpreted terminology as well as when and how to order a variety of beveled and grooved lenses.

"Unraveling the Compensated Prescription"
ABO approved level II technical course, 2 ABO credit hours
Course Description:
One of the most notable advancements in lens technology today is the frequent use of prescription compensation. An educated optician is likely to be skilled in taking the additional measurements that the lab asks for and perhaps even has a concise selling strategy. However, I aim to dig a little deeper and arm the optical professional with the knowledge of how a prescription lens changes in relation to its position of wear and how this strategic deviation from the doctor's written Rx makes sense after all.

"Can You Cut It?"
ABO approved level II technical course, 2 ABO credit hours
Course Description:
A good in-office laboratory can benefit both practice and patient. Although the proper combining of a wide variety of frame styles with infinite prescription variations can be challenging. Learn how to predict lens thickness, cut-out, and proper base curve before it becomes a breakage or delay. Reduce turn-time and cost while increasing quality and patient satisfaction.

"Fundamentals of Final Inspecting"
ABO approved level II technical course, 1 ABO credit hour
Course Description:
Opticians want to be sure that the glasses they dispense not only look great but also provide excellent vision. Quality inspection requires technical know-how as well as the correct equipment to accurately interpret measurements and properly troubleshoot variables in lens accuracy and aesthetics.

"Quick Fixes and Adjustment Tricks"
ABO approved level II technical course, 1 ABO credit hour
Course Description:
Opticians are often faced with the difficult decisions of whether or not to accept a spectacle order that is not quite up to standards. Many of these minor errors in aesthetics, prescription or frame adjustment can be fixed under your own roof without having to sacrifice turn time, cost, or quality in your final product.

EDUCATION

University of Minnesota — Minneapolis, MN
One year of coursework in Ecology, Evolution, and Behavior — 2000 - 2001

Normandale Community College — Bloomington, MN
Associate of the Arts Degree — 1999 - 2000

Statement of accordance for Rule 64B12-15.003(4)(g)

Board of Opticianry
4052 Bald Cypress Way, Bin #C08
Tallahassee, FL 32399-3258
Re: Statement of accordance for **Rule 64B12-15.003(4)(g)**

To Whom It May Concern:

Quantum Optical (FL CE provider #CE-83) is a national continuing education provider for opticians. In order to enhance the learning experience, the following online protocols have been established.

Opticians wishing to take the online course (once approved) will need to create a user account. This password protected area offers the participant the ability to take the test online and have it graded instantly.

All information is stored electronically in our database, enabling the user to view their course history at any time.

Hyperlinks that allow the participant to contact the author are on each slide in the test. This makes one-on-one interaction between student and teacher possible, although not immediate.

IP addresses are stored in our database, which helps prevent and deter fraudulent use.

Online certificates are created dynamically as images, not editable Word documents, making duplication or forgery extremely difficult. User course / test activity is reported electronically to CE Broker each calendar quarter.

Contact with the site administrator and IT support via FAQ section and e-mail.

Regards,

Michael Della Pesca, President
Quantum Optical
mike@quantumoptical.com

Digital lens technology has forever changed the optical industry. It's important to understand how it works and what makes it better. Along with explaining advancements in customization and processing. I will also help guide you through proper fitting and effective patient communication.

Digital surfacing has revolutionized the optical industry and is an entirely new way of manufacturing prescription lenses. The tools to create these lenses requires an entire line of equipment specific to digital processing. From blocking to generating to polishing, the freeform lens is created with specialized machinery from beginning to end.

Digital surfacing generators utilize a fine point diamond lathe that can create non-symmetrical complex curves on the backside of a lens. This allows for infinite possibilities in the creation of any type of lens design on the back surface of any lens puck. Comparatively, conventional lens manufacturing only allowed a single curve using a tool specific to each single-vision prescription. This required any change in curvature to be pre-molded on the front surface of the lens blank. So for any type of multi-focal, a lens has to be designed and molded by each lens manufacturer in each lens brand in every combination of add power, lens material, and lens availability. This includes all options of photochromic and polarization as well. Then these are stocked or must be ordered by the lab. The lab only applies a single vision prescription curvature on the backside of these pre-made molds.

Digital surfacing is quite the opposite. Now the progressive designs are provided to the lab in the form of software, not physical stock. This software allows for lenses to be customized per order and only require the stock of single-vision lens pucks. Any lens design with any add power can now be applied and customized per order to the very same starting lens blank of any material or lens option. When starting with only a computer program instead of physical stock, our possibilities are endless in what can be created uniquely for each patient. Any information and measurements may be utilized to design these curvatures.

The single-point diamond lathe found in freeform generators gives freeform its name. Visualize having a box of rubber stamps and an inkpad versus having a sharpened pencil and a blank piece of paper. You can imagine the limitations of conventional lap tools (the rubber stamps) as compared to a fine point that can write anything you ask it to. Digital surfacing allows the instruction for 10,000 individual points to create extreme accuracy.

This precision can be translated into prescription corrections of $1/100^{th}$ of a diopter. To this, I have always argued that the optometrist is only testing and prescribing to an accuracy of 0.25 diopter. Clearly you cannot improve upon the precision beyond what is initially measured. Not to mention that the very reason the doctor tests within the parameters of quarter steps, is that the human eye cannot detect differences more finite than that. Our correctable vision is still limited by our human anatomy. However, This initial precision in processing leads to great benefits down the line. The patient will still experience improved clarity because there is less degradation of the lens surface throughout manufacturing.

This initial accuracy allows for what is called “soft polishing” of the lens. This process creates incredibly smooth surfaces which eliminates pits, cracking, and rough spots on the lens. The lens comes out of the generator with such a clean surface that this polishing procedure requires very little material to be removed from the lens and maintains the integrity of the intended design. In comparison, traditionally surfaced lenses come out of the generator with a very rough opaque surface that requires extra fining and polishing with lap tools that have progressively finer grit polishing pads in a three part process. The accuracy of the final lens is degraded through extra refining of the lens surface as well as varying degrees of ware or damage in the tool itself.

What has changed the most in this new era of digital design is often not as apparent to opticians, but most optical laboratories are virtually unrecognizable from just 10 years ago. As we touched on earlier, the lab no longer has to stock pre-molded progressive blanks. Let’s say you have a lab that carried only ten different types of progressive designs. Still a small fraction of what was out there for conventional lens options. Now picture each of those lens designs stocked in 11 add powers, in 4 different lens materials each, in 4 different base curves each, in all options of transition grey, brown, and extra-active and multiple polarized colors. That stock alone is almost 8,000 lens pucks and a lab would need to stock multiples of the most common combinations, totaling well over 10,000 lenses. Not to mention bifocals and trifocals in every add power, segment type and lens material as well as single vision. No wonder labs look like airplane hangers, where did they put all of that? Now with the ability to make ANY lens design on the back of a single-vision blank, not only is the necessary stock drastically reduced, but the options in lens material and features are limitless.

Then there is the equipment needed. Every prescription imaginable needs a specific tool of a defined curvature to create the prescription desired on the back surface of the pre-molded lens design. These tools were stocked on huge rotating shelves. Approximately 4,000 tools had to be kept to accommodate surfacing and polishing of all prescription parameters. The programmable freeform surfacing tool eliminates the need for any such stock and drastically reduces the steps needed for producing the final product.

From the perspective of the lens manufacturer, this shift in lens making techniques has also been a game changer. Imagine for each conventional progressive design created, a unique mold had to first be created for each add power and base curve with every specific identifying mark for lens design and material built into the mold. Then actual stock had to be produced and supplied in every add power, lens material, and option for every lab that wanted to carry it around the country and the world in order for a new design to be launched. The sheer investment of time, material, and money that would go into a new progressive before it was even available wholesale was unimaginable. Let’s compare this with the launch of new digital lens designs. After the research and development, a manufacture only needs to sell labs its licensing and software that can be programmed into their existing digital surfacing equipment.

I am always careful to use the verbiage “potential” because as digital surfacing allows for sculpting of a lens that is only limited by our imagination, I can assure you that we are still very capable of limited imaginations. In many ways freeform processing is just another way to make a lens. You can very easily program in the same progressive design that was being made 25 years ago on new surfacing equipment and call it “digitally surfaced”. Just as you can use your box of rubber stamps to make a nicer picture than many can draw freehand with a sharp pencil and a blank piece of paper. It’s the design that makes the lens better, the equipment just makes it possible. And let’s think back for a moment about how much used to be invested in launching conventional lens design and how much easier and cheaper it must be to create a computer file instead. There are a lot more potential players in the game, the question you need to be asking is not is it processed on a freeform generator, but what makes one design more innovative and successful than the last?

Every prescription lens and intended progressive design will preform best on a very specific front lens curvature or “base curve”. The proper front lens curve prevents what is called spherical aberration. This is an optical effect observed by the wearer when the light rays entering the lens in the outer edges are not focusing to the same point as the rays entering through the central portion of the lens. You may ask what does the front curvature have to do with a back-surfaced lens? When we are talking about the limitations of pre-molded stock, we also must note that the base curve selection is seriously limited due to space, cost, and practicality. So some prescriptions in conventional progressives are put in the proper curve, but most are surfaced on the closest alternative. Conventional progressives are available in curves of 2, 4, 6, and 8. The ability to stock single-vision lenses in a far larger range of curvatures from 0 to as high as 12 in 1 diopter increments allows for the virtual elimination of spherical aberration. That’s a big deal for patient satisfaction in optical clarity and adaptation success in progressive lenses.

We know that the very nature of digital processing reduced many obstacles we have had in limitations of lens curve and availability. But what else can we do with our new manufacturing capabilities? The progressive manufactures are on an even playing field as far as equipment ability, but they are constantly one-upping each other with innovations in design.

In addition to Spherical aberration, there are many other optical errors that can occur with the focusing of light through a lens that can reduce visual clarity up to 20% even if a lens is surfaced accurately. These are called “higher order aberrations” and they are caused not by the patient’s vision, but by the lens itself. Aberrations are defined as any property of a lens that results in an imperfect image. Some specific ones include coma, pin cushion, or barrel distortion. Which all cause variations of curvature of field or blurred images. Many lens designs claims to eliminate unwanted aberrations through strategic processing.

This is the theory that processing the progressive corridor and magnification on the back side of the lens brings it closer to the patient's eye thus producing the effect of putting your eye closer to a keyhole and broadening your view of the other side of the door. Many digital lens companies claim the benefit of up to "30%" wider viewing in the intermediate and near zones. While it is true that the add power is brought closer to the eye, it is not THAT much closer unless we are talking about a minus 10 diopter lens to begin with. The average affect is closer to 6% wider near zones which can also be accomplished easily with increase in lens tilt or decrease in lens distance through adjustment.

Excessive lens tilt, vertex distance, and lens wrap changes the prescription that a patient views through a lens. A lens compensation based on these changes in lens position in front of the eye aims to correct for those errors in prescription. These variations in position of wear tend not to translate into noticeable differences for the patient unless they have higher prescriptions or extreme fit variations. These customizations are very useful for wrap sunglasses or prescriptions over 6 diopters, but taking extra measurements always adds value and precision to any digital lens technology.

Some lens companies have found a way to measure and customize for our patient's actual tendencies to either move their heads or just there eyes when scanning peripherally. This can be done using special digital devices that track movement through a camera or can be determined through a lifestyle questionnaire that can determine whether you engage in active or sedentary activities. These results will give "eye movers" wider spherical zones and "head movers" softer sphere slopes.

Imagine a globe (such as your eye) spinning in motion. Now picture that there is one point in the exact center that is NOT moving. This is called the "center of rotation" where the rest of the globe spins around as just that one spot remains stationary. The eye is not a perfect sphere, however, each eye no matter what its shape has a center of rotation and the exact location is determined by its length and can be a difference of up to 2mm per person. If a lens is designed with this position in mind, it can focus an image more precisely on the retina. You may be imagining how on earth are we measuring the shape and size of our patient's eye ball? But no fear, you do not need to pop out people's eyes. There is a calculation based on the patient's prescription alone that can determine the exact location of their unique center of rotation for each eye.

Digital surfacing technology is always done on only the back side of a lens. When a company claims “dual surfacing” they mean they are specially designing a partially front-molded blank and completing the digital surfacing on the back side. This allows for an even more complex design and claims to have better ability to attack focus management AND distortion reduction simultaneously. The more surfaces that are strategically utilized in any optical system, the better control you have over the final image. The human eye contains a cornea AND an intraocular lens. A telescope contains hundreds of separate lenses.

Calculations made for lenses that design each eye separately and take into account how the eyes will work together binocularly can attack issues like perceived image size and spatial perception. This can greatly improve the viewing experience of patients with a difference of two diopters or more per eye. This aims to reduce the “off balance” feeling a person can have with multifocals and creates not only a design customized for each wearer, but also personalized for each of their eyes.

The claim of having a more “ergonomic design” simply refers to the apparent placement of images through the reading portion of the lens. This design combats the natural prism induced when looking through the bottom portion of a lens in order to read. Progressives and other multifocal force us to use parts of the lens that are placed further from the optical center of the lens. The further you get from the optical center, the more displaced your image will be. The effect is opposite for plus and minus power lenses. Minus lenses will appear to move an image up in the bottom portion of the lens, where a more plus lens will displace it downward. This design incorporates opposing prism dependent on prescription to correct this.

Much of what makes each lens different is in the design approach itself, but many ask for additional measurements to be taken or customizations to be made based on frame fit or a patient’s lifestyle in order to truly personalize a lens designed and made just for that individual.

When it comes to ordering freeform lenses, many require that you provide specific measurements for the position the lens is in that particular frame as adjusted in front of that particular person's eye. Pantoscopic tilt refers to the angle at which the lens is tilted on its horizontal axis. This is measured in degrees of tilt and usually falls somewhere between 0 and 12. You should never have retroscopic tilt or what might be recorded as a negative number because the lens will likely perform poorly. In relation to the natural optical axis of the eye, you ideally should adjust a lens at 7-8 degrees of tilt.

Vertex distance refers to the measurement of the back of the lens to the front of the wearers eye. It can have an effect of total lens strength or magnification viewed by the patient

Frame wrap refers to how the lens is bent on the vertical axis. This angle can be changed through frame adjustment or curvature. Any amount of tilting of a lens on either axis in front of the eye can induce unwanted astigmatism.

Opticians used to primarily use rulers (now known as p.d. sticks) to measure pupillary distance. This, we have found to be quite inaccurate due to many factors including mis-alignment, where the patient is focusing, and pupil size and position. We have pupilometers that are much more precise because they contain prisms to mimic infinity and detect the actual optical axis through light reflection.

We now have manual devices provided by manufacturers in order to obtain position of wear measurements. These include various contraptions such as wrap layout charts, suction cup pantoscopic anglers, distometers, and yes, p.d. sticks. As mentioned before, most of these values in most of our prescriptions aren't going to have any perceivable effect on the prescription. As always, your segment height and p.d. are the values of least forgiveness. Often requiring a 1mm margin of error. This is just not so with position of wear values and often a close estimate will suffice. However it is wise to match the high tech lenses you are attempting to sell with an equally high tech device for the sale, if for nothing else, to build buyer's confidence in this new and innovative product.

There are many types of electronic devices on the market today. They are all intended to give us the additional values of vertex, wrap, and tilt, but each has a unique set of additional features. Most devices will also provide box measurements for frames as well as p.d., optical center height, and segment height. Some that are tailored to order specific lens brands will measure eye movement, center of rotation, or ask lifestyle questions to determine the very best design for your patient. You may have programs that allow for patient education on anti-reflective coatings, polarized lenses, or the dangers of blue light. Nearly all are equipped with a camera that allows for assistance in frame selection for patients who have to put their prescription glasses back on to see themselves (which frankly, should be just about all of your patients). All of these features provide a more integrated buying experience for your patient and add much value to the premium product you are selling even if they have no idea what's going on behind the scenes at your local lab.

Most digital lens designs will be customized for optimal fit and prescription distribution in you frame based off of the measured segment height. Unlike conventional designs, which had a fixed length between distance and near correction and a very limited minimum fitting height. You had to be careful to order a long or short corridor length design according to how much room you had in your lens. If ordered wrong you may have cut off the reading portion completely.

Not only do most digital designs have multiple lengths, but some let you choose which one you prefer to use. This means you can factor in other variables besides just segment height to determine the best design for your patient. The corridor length offered (for example fixed 14 or fixed 18) will refer to the minimum fitting height of that lens. That means your segment height can be the same or more than the corridor length ordered. If your seg. height matched your corridor length, you have your full allowable intermediate zone for that height and about half your total available reading zone. If you choose a shorter corridor for a higher segment height, you will be making your intermediate zone more compact and increasing the available near.

Some useful instances to look out for might include a large sunglass that sits very close to your patient's cheeks with no adjustable nose pads. If you make the corridor length as long as possible, the reading zone may not be accessible to the patient due to the frame fit. You also may ask questions regarding computer use and reading and hobbies to determine the best Rx distribution in the lens.

Why does it seem like these lenses that are supposed to be so advanced are actually making our sales more complicated? When this new technology was just being launched there was still a lot of adaptation issues for patients who were encouraged to make the switch. A lot of that I believe is due to us thinking the lenses will do all of the work for us. This is simply not true, with more ability to customize, we need to gather more information from our patients to determine what will be right for them. Putting everyone in the same thing was never wise, but also now it is no longer possible because every lens made for each patient is individualized.

We must start by knowing how our patients use their eyes. What activities they are involved in? What will their prescription will accommodate? What have they have been satisfied and dissatisfied with in their previous lenses? How has their prescription changed? What might they experience and benefit from the way you are going to customize their lens for their unique visual needs?

Just a line of questioning is not going to get you all of the information you need. Skilled observation is important and we can't rely on our digital measuring devices to catch everything. Things such as height, natural head position, and posture can determine the best alignment, corridor length, segment height, or preferred lens design. Often times when you are taking measurements it is a challenge to get someone to all of the sudden "act natural". Don't be afraid to move someone's chin or tell them to pretend to be driving or on the computer. Even the most technologically advanced precision lens will perform poorly if not positioned in front of the eye properly.

The benefits of freeform lens design are not limited to progressive lens wearers. Obviously, a single vision lens has always started with a single-vision blank, so many of the benefits we are touting do not easily apply. Digital single vision can still incorporate atoric (or complex curves) to produce better edge-to-edge clarity in a lens and reduction of many aberrations further out from the optical center of the lens. These lenses also incorporate lens compensations for position of wear.

There are also clever specializations making a lens that is smarter than the average conventional single vision lens. There are specialty wrap compensated lenses intended for sport sunwear that attempt to undo the damage done by putting a prescription in a non-ideal base curve. This opens the doors for many people to have a freer choice in frame selection by expanding the parameters possible. There are also lenses designed for the emerging presbyope. These lenses are deigned with a gradual and slight magnification in the bottom of the lens to help with near focus accommodation for patients who are not yet in need of a full progressive. This type of lens greatly benefits those 30 somethings who spend long hours on the computer making boring power-point presentations… I'm a big fan.

A specified optical center height is something you should be measuring for all single vision lenses but it is specifically required for many digital lens designs. Just as the pupil distance aligns the optical center side-to-side, the optical center height aligns it vertically. Technically this height should never be a measure of the center pupil height unless the lens has zero pantoscopic tilt. The o.c. height should be measured about 2mm below pupil height for average frame tilt (7-8 degrees). This best aligns the o.c. with the optical axis of the eye. The more tilt, the lower the o.c. should be.

Just like any measurement, its accuracy is more critical in specific prescription types. In this case, the further apart the prescribed correction from eye to eye, the more the optical center height plays a pivotal role. In prescriptions that are more than 2 diopter from eye to eye, the further the eye is from the o.c. the more unwanted prism can be induced causing double vision.

Some digital single vision designs actually correct your measurement for you. So they might grind the o.c. 2mm BELOW the measurement you provide, assuming that you measure center pupil. Always talk with your lab and understand how they are using the measurement you are providing.

Due to the complex nature and uniqueness of each lens, digital processing actually has a higher potential for human error as compared to conventional molded designs. A mold is always the same and the markings are always accurate to that mold. A digital lens is a unique snowflake and it susceptible to unchecked machine failure, calibration, mis-laser, or any number of typos in calculation or human error along the way.

If a lab is not familiar with the potential errors, limitation, or maintenance of this new technology, it can be in for a painful learning curve. Setting up a brand new assembly line process, training new employees, catching defects you are unfamiliar with, etc. We all have growing pains. Now that the creation of the lens itself happens at the lab, not the lens manufacturer, we have a few more cooks in the kitchen. Lens companies do a very good job at protecting the integrity of their product through inspection, standards, and training. I have, however seen some things slip through the cracks. It’s hard to catch specific surfacing flaws if your are not the individual that prescription was intended for. You need to look very closely for unusual waves, puckers, lens compensations outside of reasonable parameters, inaccurate laser markings, and so on.

Yes, the visual experience through your digital progressive SHOULD be a great improvement. Why are people still complaining and non-adapting? We may need a re-analysis of the fit, lens design, and measurements used. With more customizations, we unfortunately have more opportunities to get it wrong. It could also be that the human brain is a mysterious thing that does not always adapt to change well. New digital lens designs are often a pretty different visual experience. If you have adapted to a 25 year old progressive design with non-ideal base curves with peripheral aberrations, your brain is pretty set on interpreting that as your world view. Always prepare people for a realistic adaptation period with any changes to lens design. It's important not to oversell but to highlight why you are making the change and how it will be beneficial in the long run.

As an optician, your job is not an easy one. You must have an understanding of this complex technology, be proficient in recommending the best design for each person's unique visual need while limiting options and not overcomplicating your explanations. You must educate your patients in a way they will understand. Then, take precise measurements and verify that they were manufactured properly. You are not simply a sales person. However, there is definitely some song and dance needed to convince someone to invest possibly hundreds more on their lenses. Deep down, we all know our vision is of the utmost importance. It is the sense us humans rely upon more than any other. We also highly value and understand the progression and fast changing improvements in technology in so many other fields.

I drive a 1996 Jeep Cherokee and my friend just purchased a 2015 version of the same car. They are not even recognizable side by side. Although I love my cassette player and crank down windows. I also understand that a backup camera can save bumpers if not lives and an aerodynamic design and more efficient engine saves on gas mileage and helps our environment.

If you walked into your local wireless store and all they had to offer was a flip-phone, you would know immediately they were way behind the times and not giving you the best and most current the industry had to offer. This is the same for an office that offers conventional molded progressives. The difference is, your technology advancements are literally invisible to your patients. When you educate patients about freeform lenses and take the time for customizations and measurements, people will invest in a premium technology.

Field Guide to Freeform

Knowledge Assessment Quiz

1. **How is a progressive design applied conventional, non-freeform lens?**
    a. Ground on with a lap tool
    b. Molded on the front surface
    c. Etched with a lathe
    d. Molded on the back surface

2. **How is a digital freeform design created?**
    a. Freeform Lap tools
    b. A digital mold
    c. With a laser
    d. With a fine point diamond lathe

3. **What in NOT a result of digital surfacing?**
    a. Correcting vision more precisely than the doctor can refract
    b. Soft polishing
    c. Less degradation of the lens surface
    d. 1/100th of a diopter accuracy

4. **What needs to be pre-stocked for digital surfacing?**
    a. Progressive designs in every add power, base curve, and lens option
    b. Single vision lens blanks in every base curve and lens option
    c. Lap tools for every prescription
    d. Fining and polishing pads with varying degrees of grit

5. **Why are base curves more accurate in a digital lens?**
    a. The front side of the lens is digitally surfaced
    b. The freeform lens surface eliminates for spherical aberrations
    c. The freeform progressives are made in more options by the manufacturer
    d. Single vision lenses are able to be stocked in a larger range of base curves

6. **Why does a freeform lens give you the "keyhole effect"?**
    a. It is adjusted closer to the eye through increased panto
    b. The near zone is wider by design and processing
    c. The technology has "unlocked" the problem of peripheral soft focus
    d. The progressive design in on the back surface of the lens, bringing it closer to the eye

7. **What is NOT a way that freeform lenses are customized?**
    a. Position of wear measurements
    b. Right eye dominant vs left eye dominant
    c. Head movers vs eye movers
    d. Near-sighted vs far-sighted

8. **How is the center of rotation of an eye determined?**
    a. A mathematical equation based on the Rx
    b. A distometer
    c. An Ipad picture
    d. Pupil calipers

9. **What is dual surface design?**
    a. Freeform surfacing of the front and back of the lens
    b. A single vision design on the front and multi-focal design on the back
    c. A partially molded front surface with a digital backside design
    d. A digital bifocal

10. **What gives a lens "ergonomic design"?**
    a. Occupational computer lenses
    b. Improving posture through the "key hole effect"
    c. Determining whether a patient is near-sighted or far-sighted
    d. Reducing the prismatic effect in the reading zone

11. What type of position of wear measurements should you provide for lens compensation?

- **a. Retroscopic tilt**
- b. Vertix distance
- c. Pantoscopic tilt
- d. Frame wrap

12. What is NOT a benefit of having a digital measuring device?

- a. Frame selection assistance
- **b. Properly adjusting prescription eyewear**
- c. Educating patient about lens features
- d. Measuring position of wear and box measurements

13. What is useful about customizing your corridor length?

- a. The segment height can determine length of intermediate zone
- **b. Intermediate and near zone distribution can be based on frame fit or lens use**
- c. Shorter frame designs can now fit progressives
- d. The lab will always choose your best corridor length

14. Why would a patient have trouble adapting to a freeform customized lens?

- a. The lens customizations are changing the design too much
- b. A patient cannot switch from a conventional to a digital lens without adaptation issues
- c. The new technology has a lot of errors in processing
- **d. With more ability to customize, opticians must gather more information to get it right**

15. What is important for an optician to observe while taking measurements?

- a. How the frame is adjusted behind the ears
- b. Nothing, the electronic measuring device will correct for anything
- **c. Natural head position and posture**
- d. The proper pupillary distance

16. **What is a benefit of digital single vision lenses versus conventional single vision?**
    a. **Wrap lens compensations**
    b. Base curve optimization
    c. Key hole effect
    d. Dual surface design

17. **What is a problem unique to freeform manufacturing?**
    a. The add power being edged off
    b. Incorrect progressive base curve
    c. Typos in orders
    d. Lens compensation errors

18. **How can you tell if a lens has been digitally surfaced?**
    a. You can see the pixels
    b. The laser marking is on the back surface
    c. The prescription reads different from what the doctor prescribed
    d. It provides high definition vision

19. **How do you set realistic expectations for your patient's first experience in freeform technology?**
    a. They will always experience better HD vision
    b. Tell them that the lens design is more precise but may have an adaptation period due to the improvements.
    c. Any change in lens design will be met with extreme difficulty
    d. Tell them every potential non-adapt scenario so they will be pleasantly surprised when they receive there glasses; undersell, over-deliver

20. **Why would a patient stay in a conventional molded design?**
    a. They likely drive a 1996 Jeep Cherokee and use a flip phone
    b. Freeform lens technology isn't good for some people
    c. The optician did not offer or educate the patient properly regarding the benefits
    d. Conventional lenses will be around forever so if it isn't broken, don't fix it

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STATE OF FLORIDA BOARD OF OPTICIANRY

NOTICE OF MEETING

TO: **Quantum Optical, Inc.**
519 Terrace Dr.
Highland Lakes, New Jersey, 07422

PLEASE TAKE NOTICE that CE Broker course #20-790260, "Field Guide to Freeform", is on the October 23, 2020 agenda for review by the Board of Opticianry. The meeting is scheduled to begin at 9:00 A.M., EST via teleconference call. The dial-in information is:

Dial-in #: 1 (888) 585-9008 Participation Code: 123-475-828 #

You are not required to appear at this meeting. However, you are encouraged to attend. It may be helpful for you to appear in the event the Board has any questions concerning this review.

This is a public meeting and participants in this public meeting should be aware that these proceedings are being recorded and that an audio file of the meeting will be posted to the board's website.

CERTIFICATE OF SERVICE

I, HEREBY CERTIFY that a true and correct copy of the above and foregoing Notice of Meeting has been sent by U.S. Mail to the above address on this September 25, 2020.

Eric Pottschmidt
Program Operations Administrator
Email: Eric.Pottschmidt@flhealth.gov
Phone: (850) 245-4292, Facsimile: (850) 413-6982
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STATE OF FLORIDA BOARD OF OPTICIANRY

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