INSTRUCTION SHEET

NONRESIDENT MAIL-ORDER OPHTHALMIC PROVIDER
APPLICATION FOR REGISTRATION

******READ AND FOLLOW INSTRUCTIONS CAREFULLY******

FAILURE TO DO SO WILL RESULT IN DELAYING ISSUANCE

Completing the Application

1. All information must be accurate and complete. Incomplete applications will not be processed and will be returned to you for completion.
2. Information should be typed or printed legibly with black ink.
3. Complete Sections 1 through 9 on the front of the application.
4. Sign and date front of application.
5. Complete and sign Disclosure and Certification on back of application.

Fees

1.	Initial licensure	$1000.00
2.	Duplicate or replacement certificate	$50.00
3.	Issuance of certificate with change of address	$50.00

Mailing Address

Mail completed application with fee in the form of check or money order to:

Department of Financial and Professional Regulation
Attn: Division of Professional Regulation
PO Box 7007
Springfield, IL 62786

Telephone No.

For assistance in completing your application call:

Telephone: (800) 560-6420
Telecommumicative Device for the Deaf (TDD): (866) 325-4949

Additional application forms can be downloaded from the IDFPR Web site at:
www.idfpr.illinois.gov

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 83/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

NONRESIDENT MAIL-ORDER OPHTHALMIC PROVIDER APPLICATION FOR REGISTRATION

1. Name of Mail Order Ophthalmic Provider	2. FEIN No.	3. Fee
		$1000

4. Address of Mail Order Ophthalmic Provider (Street Address, City, State, Zip Code)	5. Telephone No. ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___ Toll-free Telephone No. for Responding to Patient Complaints and Questions ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___ Preferred e-Mail Address: _____

6. Is this provider licensed or registered to distribute contact lenses in the state that the dispensing facility is located? ☐YES ☐NO If yes, record your license or registration number here: _____	7. Business is Formed as: ☐ A) Sole Proprietorship ☐ B) Partnership ☐ C) Business Corporation ☐ D) Professional Service Corporation ☐ E) Limited Liability Company ☐ F) Other - Please Specify: _____

8. Names of Officers, Directors, Partners, Owners	Mailing Address Street Address, City, State, ZIP	Telephone No.

9. Name(s) of the Person(s) Who Is/Are Responsible for Overseeing the Dispensing of Contact Lenses to Illinois Residents	Mailing Address Street Address, City, State, ZIP	Telephone No.

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge they are true, correct and complete.

_____ Signature of Applicant

_____ Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorized the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee, but in no event shall such reduction be made in an amount greater than $50.

YOU MUST COMPLETE THE REVERSE SIDE OF THIS APPLICATION

MAIL ORDER OPHTHALMIC PROVIDER DISCLOSURE AND CERTIFICATION

On behalf of _____ , a mail-order ophthalmic provider, I _____, hereby certify that the mail order ophthalmic provider named above:

- Is licensed or registered to distribute contact lenses in the state in which the dispensing facility is located and from which the contact lenses are dispensed, if required;
- Complies with all lawful directions and appropriate requests for information from the appropriate agency of each state in which it is licensed or registered;
- Will respond directly to all communications from the Illinois Department of Financial and Professional Regulation concerning emergency circumstances arising from the dispensing of contact lenses to residents of Illinois;
- Maintains its records of contact lenses dispensed to residents of Illinois so that the records are readily retrievable for a minimum of 3 years;
- Will cooperate with the Illinois Department of Financial and Professional Regulation in providing information to the appropriate agency of the state in which it is licensed or registered concerning matters related to the dispensing of contact lenses to residents of Illinois;
- Conducts business in a manner that conforms with Section 10 of the Illinois Mail Order Contact Lens Act;
- Provides a toll-free telephone service for responding to patient questions and complaints during its regular hours of operation; and the toll-free number is included in literature provided with mailed contact lenses;
- Refers all questions relating to eye care for the lenses prescribed back to the contact lens prescriber;
- Provides the following or a substantially equivalent written notification to the patient whenever contact lenses are supplied: WARNING: IF YOU ARE HAVING ANY OF THE FOLLOWING SYMPTOMS REMOVE YOUR LENSES IMMEDIATELY AND CONSULT YOUR EYE CARE PRACTITIONER BEFORE WEARING YOUR LENSES AGAIN: UNEXPLAINED EYE DISCOMFORT, WATERING, VISION CHANGE, OR REDNESS; AND,
- Has received and read a copy of the Illinois Mail Order Contact Lens Act and rules for the administration of the Act which includes possible discipline and a fine up to $5,000 per violation.

_____ _____

Signature of Applicant Date

NAME (Last, First, MI):

Profession: NONRESIDENT MAIL-ORDER OPHTHALMIC PROVIDER