NMRLD
NEW MEXICO
REGULATION &
LICENSING DEPARTMENT

2023 ANNUAL RENEWAL

Your license expires on JULY 1, 2023.
You must submit this renewal form to the Board office on or before July 1, 2023

INSTRUCTIONS

1. ***Type*** or ***print*** legibly in black ink.

2. Provide ***all*** information as requested. Fill out the form completely, including all information on license status, continuing education and, other state licensure. Answer all questions.

3. Answer attestation of attendance of ***22 hours*** of Board approved continuing education (CE).

4. All Optometrists must attend a minimum of **10 hours** of CE in therapeutic pharmaceutical agents (TPA) as related to the treatment and management of ocular disease (TMOD). The **10 hours** of TPA are included in the **22 hours** of CE.

5. For optometrists on **inactive status**, a minimum of **10 hours** of continuing education in a board-approved program in clinical or ocular therapeutic pharmacology is required each renewal period, including **1 hour** of pain management CE.

6. All Optometrists must also attend a minimum of **1 hour CE** in a course that shall cover topics related to pain management, pharmacology and risks of controlled substances. ***See 16.16.15.11 NMAC - Pain Management Continuing Education***. The **1 hour** of pain management CE shall count toward the **22 hours** of continuing education.

7. Attach a copy of a current CPR certification (CPR is not considered continuing education).

8. Attach the completed Mandatory Survey: your license WILL NOT BE RENEWED unless the questionnaire is submitted with the renewal application.

9. Submit your completed application to the address listed above with the appropriate fees.

10. The ***completed*** application must be received postmarked on or before July 1, 2023.

11. **Annual Renewal forms postmarked AFTER JULY 1, 2023, must include proof of 22 hours of continuing education a late penalty fee of $325 *plus* the renewal fee of $300, for a total of $625.**

12. Practicing without a valid, renewed license is a violation of the Optometry Act and the Optometry Board's Rules.

Boards and Commissions Division | Board of Optometry
2550 Cerrillos Road | P.O. Box 25101 | Santa Fe, NM 87504
(505) 476-4622 | rld.state.nm.us

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Board of Optometry
2023 RENEWAL FORM

☐ **RENEWAL – Fee $300**
☐ **INACTIVE RENEWAL– Fee $200**
☐ **LATE – Fee $325 + $300 = $625**
☐ **INACTIVE – Fee $300**
☐ **RETIREMENT**

NMBO License #: _____

❑ ***Check to indicate changes to your address, telephone number or email address.***

Name: _____, O.D. Date of Birth:_____

Address: _____

City/State/Zip: _____

Phone: _____ Email address:_____

EDUCATION

1. **TOTAL CE hours attended: _____.**
2. I certify that I have met all continuing education requirements and will provide certificates to the Board if audited/upon request. ___ Yes ___ No

❑Yes ❑ No 1. You, the licensee, hereby certify that you are the individual named on this renewal application form and that you have provided the information requested on this form. For purposes of questions 2 through 5, a disciplinary action means any action that affects your ability to legally engage in the practice of optometry and includes, but is not limited to, suspension, probation, practice limitations, reprimand, admonition, censure or revocation of a license. Please provide details and any court document if you answer 'Yes' to questions 2 through 5.

❑Yes ❑ No 2. Has any disciplinary action been taken against your New Mexico optometry license and if licensed in another state, by that licensing board?

❑Yes ❑ No 3. Has any licensing board denied your application for an optometry license?

❑Yes ❑ No 4. Has any licensing board denied you a license renewal because of disciplinary proceedings?

❑Yes ❑ No 5. Have you knowingly failed to renew a license during an investigation or a disciplinary action?

❑Yes ❑ No 6. Have you been charged or convicted of a felony or misdemeanor (excluding traffic infractions) in any state, territory or district of the U.S. or in a foreign country? A conviction means an adjudication of guilt and includes a guilty plea, judgment, or verdict, no contest, nolo contendere, conditional plea of guilty or any other plea that would result in an adjudication of guilt in any court of competent jurisdiction. A conviction includes a

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deferred sentence and a conditional discharge. If you answer "yes", please provide court documents of the final adjudication.

❑Yes❑No 7. Do you hold a federal drug enforcement administration (DEA) registration?
DEA License number_____

❑Yes❑No 8. Do you hold a New Mexico controlled substance registration?
NM Pharmacy license number_____ Expiration date_____

❑Yes❑No 9. Are you enrolled in the Prescription Monitoring Program (PMP)?

❑Yes ❑ No 10. Are you current with your CPR Certification?
CPR Organization Name? _____
Certificate Expiration Date: __/__/_____

❑Yes ❑ No 11. I have attached the completed Mandatory Survey as required by NMSA 1978, Section 24-14C-5.

Please provide details on a separate sheet of paper and any pertinent court document if you answered 'Yes' to questions 2 through 6.

SIGNATURE: _____Date:_____

MANDATORY QUESTIONNAIRE

NMSA 1978, Section 24-14C-5(A) & (B) requires licenses of the New Mexico Board of Dental Health Care to complete a mandatory questionnaire to renew their license. **This is <u>MANDATORY</u> and your license <u>WILL NOT BE RENEWED WITHOUT IT</u>** which may result in late fees being assessed if not returned with your renewal application to the board office by June 30, 2021.

New Mexico License Number: _____

CURRENT WORK STATUS (Select all that apply)

☐ Practice in New Mexico

☐ Practice Medicine in another state: ☐ TX ☐ CO ☐ AZ ☐ Other

☐ Permanently or Temporarily Inactive in New Mexico

☐ Retired, but maintain an active license

☐ Retired and do not maintain an active license

☐ Current Resident of Fellowship Training

CURRENT ACTIVITIES

How many weeks per year do you practice in NM? _____

How many hours per week do you practice in NM? _____

For you practice in New Mexico, approximately what percent of your time was spent on the following activities (percentage of all selected activities should total 100%)

	Direct Patient Care
	Teaching/Precepting
	Research
	Healthcare Administration

	Other, please specify:_____

For Direct Patient Care, approximately what percent of your time was spent in the following types of facilities (percentage should total 100%)

	Hospital/Inpatient
	Outpatient/Clinic
	Mobile Services
	Other, please specify:_____

LOCATION OF EDUCATION AND TRAINING

	New Mexico	Other U.S. state or Canada	Foreign country	Not Applicable
Location of the high school from which you graduated:	☐	☐	☐	☐
Location of the undergraduate college or university from which you graduated:	☐	☐	☐	☐
Location of the licensure training from which you graduated:	☐	☐	☐	☐
Location of primary specialty training:	☐	☐	☐	☐
Location of secondary specialty training:	☐	☐	☐	☐

PRACTICE SPECIALTY(IES) IN WHICH YOU SPEND MOST OF YOUR PROFESSIONAL TIME

Primary Specialty: _____

% Patient care time for primary specialty: _____

Secondary Specialty: _____

% Patient care time for secondary specialty: _____

TRAINING AND CERTIFICATION

	Yes	No
Completed accredited residency programs for primary specialty?	☐	☐
Board certified/Certificate of Added/Special Qualifications for primary specialty?	☐	☐
Completed accredited residency programs for secondary specialty?	☐	☐
Board certified/Certificate of Added/Special Qualifications for secondary specialty?	☐	☐

HOSPITAL ADMITTING PRIVILEGES

Number of hospitals in New Mexico at which you have admitting privileges

☐ None ☐ One ☐ Two ☐ Three or more

REIMBURSEMENT: PAYMENT SOURCES

Primary source of payment for patient care (**select top 3**):

☐ Medicare
☐ Medicaid
☐ Tricare/VA/HIS
☐ Private Insurance
☐ Self-pay
☐ Bad Debt/Charity
☐ Other

☐ Do Not Know or Not Applicable
☐ Other:_____

% of patients with Medicare as their primary payer: _____
% of patients with Medicaid as their primary payer: _____
% of patients with Tricare/VA/HIS as their primary payer: _____
% of patients with Private Insurance as their primary payer: _____
% of patients with Self-pay as their primary payer: _____
% of patients with Bad Debt/Charity as their primary payer: _____
% of patients with Other as their primary payer: _____

Provide an approximate monetary value for the **uncompensated** patient care you provided during the last year for **emergency** services: [ ]

Provide an approximate monetary value for the **uncompensated** patient care you provided during the last year for **non-emergency** services: [ ]

PATIENT CARE PRACTICE LOCATIONS

For PRIMARY location of patient care:

PRIMARY patient care street address:	
PRIMARY patient care city/town:	
PRIMARY patient care state:	
PRIMARY patient care 5-digit zip code:	
Weekly PRIMARY patient care hours:	
Weekly PRIMARY number of patients:	

For SECONDARY location of patient care:

SECONDARY patient care street address:	
SECONDARY patient care city/town:	
SECONDARY patient care state:	
SECONDARY patient care 5-digit zip code:	
Weekly SECONDARY patient care hours:	
Weekly SECONDARY number of patients:	

PRACTICE SETTINGS

What best describes your PRIMARY location practice?

☐ Independent Practice
☐ Group practice-Employee/Staff
☐ Organizationally affiliated (ie University, or Health Plan staff)
☐ Hospital-Inpatient
☐ Hospital-Outpatient dept/satellite clinic
☐ Hospital-Emergency room
☐ Federal Qualified Health Clinic (FQHC)
☐ Nursing home/Home Health agency
☐ Private health center/clinic
☐ Public/Non-profit community health center (non-FQHC)
☐ Other licensed community clinic
☐ Military/VA health facility

- ☐ Indian Health Service clinic
- ☐ Locum tenens
- ☐ Multi-Specialty Practice-Employee/staff
- ☐ Nurse Managed Clinic
- ☐ Other (please specify): _____

What best describes your PRIMARY location practice size?

- ☐ Solo Independent Practitioner
- ☐ Solo Independent Practitioner + Intermediate
- ☐ Two Independent Practitioners
- ☐ Three or Four Independent Practitioners
- ☐ Five to Nine Independent Practitioners
- ☐ Ten or More Independent Practitioners

What best describes your SECONDARY location practice?

- ☐ Independent Practice
- ☐ Group practice-Employee/Staff
- ☐ Organizationally affiliated (ie University, or Health Plan staff)
- ☐ Hospital-Inpatient
- ☐ Hospital-Outpatient dept/satellite clinic
- ☐ Hospital-Emergency room
- ☐ Federal Qualified Health Clinic (FQHC)
- ☐ Nursing home/Home Health agency
- ☐ Private health center/clinic
- ☐ Public/Non-profit community health center (non-FQHC)
- ☐ Other licensed community clinic
- ☐ Military/VA health facility
- ☐ Indian Health Service clinic
- ☐ Locum tenens
- ☐ Multi-Specialty Practice-Employee/staff
- ☐ Nurse Managed Clinic
- ☐ Other (please specify): _____

What best describes your SECONDARY location practice size?

- ☐ Solo Independent Practitioner
- ☐ Solo Independent Practitioner + Intermediate
- ☐ Two Independent Practitioners
- ☐ Three or Four Independent Practitioners
- ☐ Five to Nine Independent Practitioners
- ☐ Ten or More Independent Practitioners

CURRENT PRACTICE CAPACITY

What describes your current patient care practice capacity?

- ☐ My practice is full: I cannot accept any new/additional patients
- ☐ My practice is nearly full: I can accept a few new/additional patients
- ☐ My practice is far from full: I can accept new/additional patients
- ☐ Not Applicable

MEANINGFUL USE OF HEALTH INFORMATION TECHNOLOGY (HIT) AND ELECTRONIC HEALTH RECORD (EHR) IN YOUR PRACTICE

Does your practice CURRENTLY have the following HIT/EMR capacity? (select all that apply)	
☐	Computerized Provider Order Entry (CPOE)
☐	E-Labs (Order, Retrieve and Store results)
☐	Create Registries (e.g. registry of patient with diabetes)
☐	Quality Reporting
☐	Record Demographics (e.g. patient race/ethnicity, insurance status)
☐	Patient access to electronic copy of health records
☐	E-Prescribing
☐	Patient timely access to labs, x-ray and other results
☐	Record Vital Signs (e.g. height, weight, blood pressure)
Does your practice PLAN TO HAVE IN THE NEXT YEAR? (select all that apply)	
☐	Computerized Provider Order Entry (CPOE)
☐	E-Labs (Order, Retrieve and Store results)
☐	Create Registries (e.g. registry of patient with diabetes)
☐	Quality Reporting
☐	Record Demographics (e.g. patient race/ethnicity, insurance status)
☐	Patient access to electronic copy of health records
☐	E-Prescribing
☐	Patient timely access to labs, x-ray and other results
☐	Record Vital Signs (e.g. height, weight, blood pressure)

REFERRAL DIFFICULTIES

Identify the specialties that you or your patients have the greatest difficulty scheduling/obtaining/arranging a timely appointment **when making referrals** (MARK UP TO 3 SPECIALTIES)

☐ Advanced practice certified chiropractor
☐ Social Worker
☐ Social Worker - Clinical Specialty
☐ Social Worker - Medical Specialty
☐ Social Worker - School Specialty
☐ Social Worker - Researcher
☐ Social Work - Community Organizer
☐ Social Work Administrator
☐ Dental Public Health
☐ Endodontic
☐ Oral and maxillofacial surgery
☐ Orthodontics and dento-facial orthopedics
☐ Oral pathology
☐ Pediatric dentistry
☐ Periodontology
☐ Acupuncturists
☐ Cardiology/Vascular Specialists

☐ Chiropractors
☐ Dermatology
☐ Diabetic Educators
☐ Gynecology (only)
☐ Endocrinology and Metabolism
☐ Primary Care - Internal Medicine, Family
☐ Practice, Pediatrics, Geriatrics
☐ Infectious Disease
☐ Mental Health Adult, Child and Adolescent
☐ Nephrology
☐ Neurology
☐ Nutritionists
☐ Occupational /Rehabilation-Physiary
☐ Medicine
☐ Oncology/Hematology
☐ Orthotists/Prosthetics
☐ Pain Management
☐ Physical Therapy
☐ Rheumatology
☐ Other - _____

RECRUITMENT EXPERIENCES

How would you describe your experience in recruiting:	Easy	Somewhat Difficult	Very Difficult	Not Known or Now Applicable
Physicians	☐	☐	☐	☐
Nurses	☐	☐	☐	☐
Nurse Practitioners	☐	☐	☐	☐
Physician Assistants	☐	☐	☐	☐
Other Health Professionals	☐	☐	☐	☐

DEMOGRAPHIC INFORMATION

Gender: ☐ Male ☐ Female

Hispanic, Latino or Spanish Origin: ☐ Yes ☐ No

Race (Select all that apply):

☐ White or Caucasian

☐ Black or African American
☐ Native American or Alaska Native
☐ Asian or Pacific Islander
☐ Other: _____

NEAR FUTURE PRACTICE PLANS

In the next 12 months I plan to (select all that apply):
☐ Retire from patient care
☐ Significantly reduce patient care hours
☐ Move my practice to another geographic location in New Mexico
☐ Move my practice out of New Mexico
☐ None of the above

If you are retiring, moving or reducing patient care hours in the next 12 months, what are the factors that led to that decision? (select all that apply)
☐ Age
☐ Geographic preference
☐ Health
☐ Practice Environment
☐ Lack of Job Satisfaction
☐ Gross Receipts Tax
☐ Increasing Administrative/Regulatory Burden
☐ Reimbursement Issues
☐ Other: _____
☐ N/A

PROFESSIONAL LIABILITY INSURANCE INCREASE THRESHOLDS
At what percent increase in your annual liability insurance above your current level would you consider:

Retiring from patient care?	%
Significantly reduce patient care hours?	%
Moving practice out of state?	%

MEDICARE PAYMENT DECREASE THRESHOLDS
At what percent decrease to your Medicare payment level would you consider:

Retiring from patient care?	%
Closing practice to NEW Medicare patients	%
Closing practice to ALL Medicare patients	%
Significantly reduce patient care hours?	%
Moving practice out of state?	%

When billing for services:
☐ Submit billing through own license
☐ Submit billing through someone else's license
☐ Submit billing through Group/Hospital ID
☐ Do not know
☐ Other (please specify): _____