



**THE COLLEGE OF OPTOMETRISTS OF BRITISH COLUMBIA**

906 - 938 Howe Street, Vancouver, BC V6Z 1N9  
Tel: 604 623 3464 | Fax: 604 623 3465 | www.optometrybc.com

**FORM 10: REGISTRATION RENEWAL APPLICATION**

Please complete this form in **ink** and BLOCK LETTERS.

**NAME INFORMATION AND REGISTRATION**

\_\_\_\_\_  
First Name                                      Middle name                                      Last name                                      Registration number

**Indicate your**

**Registration class:**

Therapeutic qualified       Non-therapeutic qualified       Non-practising\*       Academic\*\*

If you are renewing registration as a therapeutic qualified or non-therapeutic qualified registrant:

- Have you provided optometric services during the past year?                                      Yes [ ] No [ ]
- If you have not provided optometric services during the past year, when did you last provide optometric services?

\_\_\_\_\_  
Day/month/year

If you are renewing registration as a non-practising or academic registrant, when were you granted registration in this class?

\_\_\_\_\_  
Day/month/year

**CONTACT INFORMATION**

Home Phone: \_\_\_\_\_ Home Fax: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

**MAILING ADDRESS**

Suite: \_\_\_\_\_ Building Name/Clinic Name \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

**PERSONAL INFORMATION**

Gender:                      M                       F

Date of birth:                      \_\_\_\_\_  
   Day    Month    Year

**LANGUAGE FLUENCIES**

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

**PLACE OF PRACTICE INFORMATION**

Please provide the name, address, telephone and fax numbers for each of your places of practice and indicate your mode of practice at each location and which days of the week you practise there.

**Location 1 (Clinic Name):** \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Extension: \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email/Website: \_\_\_\_\_

Practice days: S  M  T  W  Th  F  S

Mode of practice (circle one): Sole owner Co-owner Employee Contractor

**Location 2 (Clinic name)** \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Extension: \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email/Website: \_\_\_\_\_

Practice days: S  M  T  W  Th  F  S

Mode of practice (circle one): Sole owner Co-owner Employee Contractor

**Location 3 (Clinic Name):** \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Extension: \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email/Website: \_\_\_\_\_

Practice days: S  M  T  W  Th  F  S

Mode of practice (circle one): Sole owner Co-owner Employee Contractor

**Location 4 (Clinic Name):** \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Extension: \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email/Website: \_\_\_\_\_

Practice days: S  M  T  W  Th  F  S

Mode of practice (circle one): Sole owner Co-owner Employee Contractor

Please continue on a separate page if necessary

**CRIMINAL RECORD CHECK DECLARATION**

It is mandatory that you declare: (1) criminal records to the college on the annual renewal form, and (2) criminal records any time during the current registration year should a criminal record arise in which case you must provide a new authorization for a criminal record check. Criminal record checks are also required every five years.

Have any charges and/or convictions for criminal offenses occurred since your last criminal check: Yes  No

**CONTINUING EDUCATION DECLARATION**

I have completed the requirements of the quality assurance program as set out in part 5 of the bylaws: Yes  No

**CPR DECLARATION**

As a condition of annual registration in the province of BC you are required to have a valid CPR level of certification by October 31.

I have completed a CPR course or CPR re-certification within the last 3 years: Yes  No

**PRACTISE IN OTHER JURISDICTION(S) DECLARATION**

If you are registered or licensed to practise optometry in any other jurisdiction, indicate which jurisdiction(s) and confirm that you are in good standing in those jurisdictions.

Jurisdiction: \_\_\_\_\_ In good standing? Yes  No

Jurisdiction: \_\_\_\_\_ In good standing? Yes  No

**INSURANCE DECLARATION**

Section 61 of the Bylaws provides:

- (1) Each full registrant or academic registrant must obtain and at all times maintain professional liability insurance with a limit of liability not less than \$2,000,000 per occurrence insuring against liability arising from an error, omission or negligent act of the registrant.

I have professional liability insurance in accordance with section 61? Yes  No

**NON-PRACTISING REGISTRANT DECLARATION**

If you are renewing as a non-practising registrant, do you acknowledge your declaration that you will not provide the services of the profession of optometry in British Columbia while registered in the college as a non-practising registrant? Yes  No

**ACADEMIC REGISTRANT DECLARATION**

If you are renewing as an academic registrant, do you acknowledge your declaration that you will not provide optometric services in British Columbia except for educational purposes in an instructional setting? Yes  No

I, \_\_\_\_\_, solemnly declare that the information contained in this form, including all accompanying documentation, is true, accurate and complete to the best of my knowledge,

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date