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 12: REINSTATEMENT APPLICATION

Please complete this form in **ink**.

NAME AND REGISTRATION NUMBER

____ _______________________

Name (fist, middle, last) Previous registration number

OTHER NAMES USED OR HAVE USED: (e.g. maiden name, birth name or previous married name)

____

First name Middle name(s), if any Last name

CONTACT INFORMATION

Please provide your telephone numbers, fax number (if any) and e-mail address.

Home Phone: ______________________ Cell Phone: ________________________________

Work Phone: ______________________ Email: ________________________________

Please provide your home address, work address (if any) and mailing address (if different from your home address).

Home: ____

Work: ____

Mailing: ____

PERSONAL INFORMATION

Date of birth: _______/________/ ________ Mother's maiden name___________________________

Day month year (for security purposes)

REGISTRATION CLASS
Please indicate which registration class you are applying to be reinstated to (check one):

Therapeutic qualified [ ] **Non-therapeutic qualified [ ]** **Non-practising* [ ]** **Academic** [ ]**

*Applicants for the non-practising registration class must complete a statutory declaration in Form 8.

**Applicants for the academic registration class must complete a statutory declaration in Form 8A.

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

____
Day/month/year

REINSTATEMENT INFORMATION

When did you leave practice or otherwise become unregistered with the College of Optometrists?

____
Day/month/year

Why?____

____

____

PRACTISE IN OTHER JURISDICTIONS

Have you ever practised or been registered or licensed to practise optometry or any other health profession in

(a)	another province or territory?	[ ] Yes [ ] No
(b)	a US state?	[ ] Yes [ ] No
(c)	any other country?	[ ] Yes [ ] No

If Yes, where? ____

If you have previously practised optometry or any other health profession in another jurisdiction or another health profession in British Columbia, you must provide a letter of good standing from each previous regulatory authority, to be delivered to the registrar by the issuing regulatory authority.

Have you ever been subject to a disciplinary action or been prohibited from practising optometry or any other health profession in British Columbia or another jurisdiction?

[ ] Yes [ ] No

If Yes, please state when and under what circumstances.

____

____

____

____

PLACES OF PRACTICE

If you are reinstated, where will you practice? Please give the name, address, telephone and fax numbers, email address and web site (if any) for each of your places of practice and indicate your intended mode of practice at each location. Continue on a separate page if necessary.

Location 1:____

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 (check one): Sole practitioner [ ] Contractor [ ] Employee [ ] Co-owner [ ]

If you would not be a sole practitioner at this location, please name the person(s) or BC optometric corporation(s) with whom you would practice:

____

Location 2:____

Address: ____

Telephone: ____________ Fax: ______________ Email/Web: ______________________________

Mode of practice (check one): Sole practitioner [ ] Contractor [ ] Employee [ ] Co-owner [ ]

If you would not be a sole practitioner at this location, please name the person(s) or BC optometric corporation(s) with whom you would practice:

____

Please give the name and address of any other places of practice or optometric corporations in which you have an ownership interest.

____

____

DOCUMENTS

Please provide or arrange to provide the following original documents to the college registrar:

- Authorization for a criminal record check (for applicants who have resided in another jurisdiction, an authorization for a criminal record check in that jurisdiction or a criminal record report in a form satisfactory to the registrar)
- A passport photo, to be taken within 6 months of completion of this application.
- Proof of Canadian citizenship or permanent resident status in Canada or authority to work in Canada in a health care profession.
- Letter of good standing from each previous regulatory authority that has registered, licensed, certified or otherwise authorized the applicant to practice optometry or another health profession (applicant who has practised or is practising in another jurisdiction or who has practiced or is practising in another health profession in British Columbia or another jurisdiction, **to be delivered to the registrar by the issuing regulatory authority.** The letter of good standing should confirm the applicant's good standing in the other jurisdiction at the time he or she ceased practising in the other jurisdiction or ceased practising the other health profession or both, as applicable, and confirming the person's good standing in any health profession in which he or she is currently practising.
- Proof of continuing education credits obtained within two years of completion of this application.

STATUTORY DECLARATION

I,____, declare that the information in this form including all accompanying documentation, is true, accurate and complete and that during the preceding year I have completed the requirements of the quality assurance program as set out in Part 5 of the bylaws.

I make this solemn declaration conscientiously believing it to be true and knowing that it is of the same legal force and effect as if made under oath.

Declared before me at______________________)
)
this______ day of_______________, 20_________)
)
Name: __________________________________) ____
) Signature of applicant
Address:_____________________________________)

____

____

[ ] A commissioner for taking affidavits in British Columbia

[ ] A notary public in and for British Columbia

[ ] A commissioner authorized to administer oaths in the courts of justice of

____
Jurisdiction

PROFESSIONAL LIABILITY INSURANCE: I understand that it is my responsibility to obtain and at all times maintain professional liability insurance with a limit of liability not less than $2,000.000 per occurrence.

NOTICE OF RIGHT TO REVIEW: Applicants for registration with the College of Optometrists of British Columbia may apply in writing to the Health Professions Review Board for a review of a registration decision within 30 days of the day on which you received written notice of the decision. For more information, see Part 4.2 of the *Health Professions Act*.

CHANGES IN YOUR REGISTRATION INFORMATION: Please notify the College of Optometrists of British Columbia as soon as possible if any of the information set out in this Registration Application changes.

For office use only

____ ____
Registration No. Date