

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 (choose 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 (choose 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 (choose 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