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 ☐

QUALITY ASSURANCE PROGRAM 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