College of
HEALTH AND CARE
PROFESSIONALS OF BC

OPTOMETRY

FORM 10: REGISTRATION RENEWAL APPLICATION

NAME AND REGISTRATION INFORMATION

____
First name   Middle name   Last name   Registration number

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

The College collects data on sex at birth, gender and pronouns. Sex at birth is required for criminal record checks and health system data. Gender data helps the College work towards better supporting equity, diversity and inclusion. Pronouns ensure we know the correct language to use when referring to you in the third person. Indicating your gender and/or pronouns is optional.

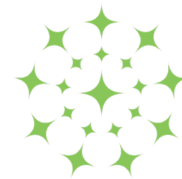
Date of birth: ____________________ Sex at birth: Female ☐ Intersex ☐ Male ☐
day/month/year

Gender: Man ☐ Non-binary ☐ Woman ☐ Prefer not to answer ☐

Pronouns: he/him ☐ he/they ☐ she/her ☐ she/they ☐ they/them ☐ ze/zir ☐
Use my name/no pronouns ☐ Prefer not to say ☐ Other set of pronouns ☐ : ______________
Specify (optional)

LANGUAGE FLUENCIES

Please list: ____



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. Use additional pages as needed.

Location 1 (Clinic name) ______________________________

Street address: ______________________ City: ______________

Province: ______________ Postal code: ____________ Country: ______________

Email: ______________________ Website: ______________________

Phone: ______________ Ext: ________ Fax: ______________ Effective date:

Practice days: S ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ S ☐ ____________________ day/month/year

Mode of practice: Sole owner ☐ Co-owner ☐ Employee ☐ Contractor ☐

Location 2 (Clinic name) ______________________________

Street address: ______________________ City: ______________

Province: ______________ Postal code: ____________ Country: ______________

Email: ______________________ Website: ______________________

Phone: ______________ Ext: ________ Fax: ______________ Effective date:

Practice days: S ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ S ☐ ____________________ day/month/year

Mode of practice: Sole owner ☐ Co-owner ☐ Employee ☐ Contractor ☐

Location 3 (Clinic name) ______________________________

Street address: ______________________ City: ______________

Province: ______________ Postal code: ____________ Country: ______________

Email: ______________________ Website: ______________________

Phone: ______________ Ext: ________ Fax: ______________ Effective date:

Practice days: S ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ S ☐ ____________________ day/month/year

Mode of practice: Sole owner ☐ Co-owner ☐ Employee ☐ Contractor ☐

Location 4 (Clinic name) ______________________________

Street address: ______________________ City: ______________

Province: ______________ Postal code: ____________ Country: ______________

Email: ______________________ Website: ______________________

Phone: ______________ Ext: ________ Fax: ______________ Effective date:

Practice days: S ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ S ☐ ____________________ day/month/year

Mode of practice: Sole owner ☐ Co-owner ☐ Employee ☐ Contractor ☐

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 Schedule 21 of the Bylaws:

Yes ☐ **No** ☐

CPR DECLARATION

As a condition of annual registration in the province of British Columbia 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

Schedule 5, sub-section 8 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 the Bylaws: **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,
Name

including all accompanying documentation, is true, accurate and complete to the best of my knowledge.

________________________________ ____________________
Signature day/month/year