College of
HEALTH AND CARE
PROFESSIONALS OF BC

OPTOMETRY

FORM 12: REINSTATEMENT APPLICATION

NAME AND REGISTRATION INFORMATION

First name _____ Middle name _____ Last name _____ Registration number _____

Other names (e.g., maiden name, birth name, previous married name) _____

CONTACT INFORMATION

Home phone: _____ Work phone: _____ Cell: _____

Email: _____ Fax: _____

Home address

Street address: _____ City: _____

Province: _____ Postal code: _____ Country: _____

Mailing address (if different from above)

Address or P.O. Box: _____ City: _____

Province: _____ Postal code: _____ Country: _____

Work address (if any)

Suite: _____ Building name/Clinic name: _____

Street address: _____ City: _____

Province: _____ Postal code: _____ Country: _____

PERSONAL INFORMATION

Date of birth: _____ (day/month/year) Mother's maiden name: _____ (For security purposes)

REGISTRATION CLASS

Please indicate in which registration class you are applying to reinstate.

Select 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 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

REINSTATEMENT INFORMATION

When did you leave practice or otherwise become unregistered with the College? _____
day/month/year

Why? _____

_____

_____

PRACTICE IN OTHER JURISDICTIONS

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

another province or territory? Yes ☐ No ☐
a U.S. state? Yes ☐ No ☐
any other country? Yes ☐ No ☐

If Yes (to any of the above), please indicate 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: _____

_____

_____

_____

_____

PLACE OF PRACTICE INFORMATION

If you are reinstated, where will you practice? Please provide the details of each place of practice and indicate your intended mode of practice at each location and which days of the week you will 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 ☐

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 practise: _____

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 ☐

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 practise: _____

Please give the name and address of any other place of practice or optometric corporation 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 the information in this form, including all accompanying
Applicant for reinstatement
documentation, is true, accurate and complete and that during the past year I have completed the requirements of the quality assurance program as set out in Schedule 21 of the CHCPBC 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 _____

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

_____
Signature of applicant

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 Health and Care Professionals 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 advise the College of Health and Care Professionals of British Columbia as soon as possible if any of the information set out in this application changes.

FOR OFFICE USE ONLY _____ _____
Registration Number day/month/year