College of
HEALTH AND CARE
PROFESSIONALS OF BC

OPTOMETRY

FORM 7: REGISTRATION APPLICATION

NAME

First name _____ Middle name _____ Last name _____

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 be registered.

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, provided by CHCPBC.

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

EDUCATION

Please describe your educational credentials (from university onwards).

Institution	Period of attendance	Degree or qualification

Please indicate which of the following (if any) you have successfully completed. You must provide copies of academic transcripts showing the results of all examinations you have successfully completed.

OT ☐ TMOD ☐ 100-hour TMOD course & exam ☐ Upgrade TMOD course ☐

DOCUMENTS

Please provide or arrange to provide the following original documents to the College:

- 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 optometry or another health profession in another jurisdiction or who has practised 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 should confirm the applicant's good standing in the other jurisdiction at the time they ceased practising in the other jurisdiction or ceased practising in the other health profession or both, as applicable, and confirming the person's good standing in any health profession in which they are currently practising.
- Proof of **continuing education credits** obtained within two years of completion of this application.

For an applicant who has practised or is practising optometry in another jurisdiction or who has practiced or is practising in another health profession in British Columbia or another jurisdiction, please provide a statement that lists any outstanding complaints, claims, actions, inquiries or proceedings against the applicant in British Columbia and/or any other jurisdiction in relation to the practice of a health profession.

Please arrange to have the following documents sent directly to the College by the issuing authority:

- Academic transcript from the recognized school of optometry attended. The transcript must indicate that the course leads to a Doctor of Optometry degree.
- National qualifying examination or national qualifying examination equivalent transcript.

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 and which health profession(s):

_____

_____

DISCIPLINE HISTORY

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

Yes ☐ No ☐

If Yes, please state when and under what circumstances:

_____

_____

_____

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_____

STATUTORY DECLARATION

I, _____, solemnly declare that
Applicant for registration

a) I am legally entitled to live and work in Canada,

b) I am 19 years of age or older, and

c) the information contained in this registration application, including all accompanying documentation, is true and accurate to the best of my knowledge,

and 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