

## Continuing Education Activity Accreditation Request Form

Please complete all sections of this form completely. Please complete electronically or clearly print. The information contained on this form will be used by the College in carrying out its regulatory activities only for the purpose of regulating the profession in the public interest. Please complete all sections below.

### A. Provider Information

Name of Organization

Name		Position	
Street Number	Street Name		Unit / Suite Number
P.O. Box	City	Province	Postal Code
Phone	Fax	Email	

### B. CE Activity Submission Information – *Supporting Documentation Required*

Exact Title of CE Activity Submitted

In accordance with the [Accreditation Policy](#), an accredited activity must be available to all Ontario opticians. Please explain how this activity will be available to all Ontario opticians:

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<p><b>Type of CE Activity (Please check all that apply)</b></p> <p><input type="checkbox"/> Contact Lens (CL)</p> <p><input type="checkbox"/> Eyeglasses (EG)</p> <p><input type="checkbox"/> Refracting (RF)</p> <p><input type="checkbox"/> Professional Growth (PG)</p> <p><input type="checkbox"/> Live Presentation</p> <p><input type="checkbox"/> Distance Learning/Online</p>	<p><b>Level of Knowledge and Skill Required by Participants</b></p> <p><input type="checkbox"/> Advanced</p> <p><input type="checkbox"/> Entry-Level</p> <p><input type="checkbox"/> Intermediate</p> <p><input type="checkbox"/> Refracting Optician</p>
<p><b>Date(s) of CE Activity</b></p>	<p><b>Is this a Previously Accredited CE Activity?</b></p> <p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p>
<p><b>Length of CE Activity (Word Count or Time)</b></p>	<p><b>If 'Yes' was selected, please specify the CE Activity ID# assigned by the COO:</b></p>

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**Speaker(s)\***

1. Full Name \_\_\_\_\_ Title/Position \_\_\_\_\_

2. Full Name \_\_\_\_\_ Title/Position \_\_\_\_\_

**\*Please enclose a short biography or CV specifying the professional designation and or title, education and affiliation of each speaker. Please attach additional sheets of paper to this form.**

**C. Location(s) of CE Activity – if applicable**

Name of Venue \_\_\_\_\_

Street Number	Street Name		Unit / Suite Number
P.O. Box	City	Province	Postal Code
Phone	Fax	Email	

**D. Learning Outcomes of Activity**

**Please describe, in detail, the specific learning outcomes of the submitted activity (skills, activities or items of information) which attendees will be expected to incorporate into their professional duties:**

**F. Signature**\_\_\_\_\_  
Signature\_\_\_\_\_  
Date

### G. Review Fee and Timeline

Please indicate the requested review fee and timeline:

- \$84.75 Standard Accreditation Review** (submitted more than 45 days prior to the scheduled event)
- \$226.00 Fast Track Accreditation Review** (submitted between 45 to 10 days prior to the scheduled event)
- \$565.00 Rush Accreditation Review** (submitted less than 10 days prior to the scheduled event)
- \$28.25 CE Activity Accreditation Renewal** (limit of (1) renewal per previously accredited CE activity)

\*All fees include applicable taxes (HST)

### H. Credit Card Authorization

Last name		First Name	
Type of Credit Card <input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD		Total Amount to be Charged	
Card Number			
Exp. Date /		Signature for Authorization of Payment	

Please submit this application to the college in one of the following methods

By email to: [ga@collegeofopticians.ca](mailto:ga@collegeofopticians.ca)

By fax to: 416-368-2713

\*Submission via Dropbox files is also acceptable for very large documents.