College of Opticians of Ontario

(416) 368-3616
(800) 990-9793 (Toll-Free)
(416) 368-2713

APPLICATION FOR A CERTIFICATE OF REGISTRATION

Which Certificate of Registration are you applying for? ○ Student ○ Intern ○ Optician (Please Select)

GENERAL INFORMATION

Legal Name

Last Name: First Name: Middle Name:

Former Legal Name(s):

Last Name: First Name: Name Used in Practice:

Date of Birth: / /
dd / mm / yyyy

Gender: ○ M ○ F ○ X

Please provide a notarized copy of a legal document confirming your name (e.g. driver's license) and a signed passport style photo taken within the last 6 months

Contact Information

Email Address:
Alternate Email Address:
Primary Phone #:
Alternate Phone #:

Home Address

Street Address:
City:
Province:
Postal Code:
Country:

Languages of Care

Which language is your primary language of care? (the language you can fluently read, write, and speak in):

○ English ○ French

What additional languages can you provide professional services in?

(Please Select) (Please Select) (Please Select) (Please Select)

Employment Eligibility

Are you a Canadian citizen or permanent resident of Canada? ○ Yes ○ No

If "Yes", please provide either a notarized copy of your Canadian birth certificate, Canadian passport, certificate of Canadian citizenship, or permanent resident card.

If "No", please provide details about your current citizenship and a notarized copy of your work permit from Citizenship and Immigration Canada permitting you to engage in the practice of Opticianry in Canada.

If you are applying for a student Certificate of Registration, you may provide a notarized copy of your study permit from Citizenship and Immigration.

EDUCATION

Opticianry Related Education*

Education Level	*Educational Institution*	*Program Name*	*Location*	*Date Started*	*Date Completed*
(Please Select)				/ /	/ /
(Please Select)				/ /	/ /
(Please Select)				/ /	/ /
(Please Select)				/ /	/ /

* Please provide a letter from your educational institution confirming your enrollment/ graduation from the program

Are you currently undergoing, or have you previously undergone, the Prior Learning Assessment and Recognition process in another province? ○ Yes ○ No

Have you successfully completed the National Association of Canadian Optician Regulators (NACOR) Exams? ○ Yes ○ No

If "Yes", please indicate the year(s) of successful completion _____

Have you successfully completed 1000 hours of verified dispensing experience (including at least 250 eye glass and 20 contact lens fittings)? If "Yes", please complete Form A or provide a letter from your education program confirming completion of the dispensing requirements. ○ Yes ○ No

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Education Not Related to Opticianry*

Please list all completed post-secondary education not related to Opticianry

Education Level	*Field of study*	*Educational Institution*	*Program Name*	*Location*	*Date Completed*
(Please Select)	(Please Select)				/ /
(Please Select)	(Please Select)				/ /
(Please Select)	(Please Select)				/ /
(Please Select)	(Please Select)				/ /

* Please provide proof of graduation from the program(s) listed in this section

PRACTICE HISTORY

Are you currently practising or previously registered/licensed to practise Opticianry in any jurisdiction, province, state or country outside of Ontario? ○ Yes* ○ No

Are you currently practising or previously registered/licensed to practise any other profession in any jurisdiction, province, state or country? ○ Yes* ○ No

Have you previously been registered with the College of Opticians of Ontario? ○ Yes ○ No

* Please complete the information below, and provide a completed Form B from each jurisdiction, province, state or country in which you were registered to practise

Regulatory/Licensing Body	*Country/Province/State*	*License/Registration Number*	*Registered/Licensed From*	*To*
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /
			/ /	/ /

PRACTICE INFORMATION

Are you currently employed or have you been offered a position in Opticianry? ○ Yes ○ No*

If "No", are you currently seeking employment in Opticianry? ○ Yes ○ No

Please note that if you are employed or self-employed but not in opticianry, you must provide the address of the location where you currently work the most hours. If you are not employed or self-employed in Ontario, or do not have a business address, you may designate an alternate address, such as a post office box, or your last place of employment. You should not list your home address as your practice address unless you are working from your home and your home address is your business address. **All addresses listed in the section below will become public information and will appear on the College's Public Register.** If you have questions or concerns about this, please contact the College.

Do you have current professional liability insurance in the amount of no less than $1,000,000? ○ Yes ○ No

If "Yes", please complete Form C – Insurance Information. If "No", please complete Form C – Undertaking

Primary Practice Address

Business Name:

Address:

City:

Province/Territory:

Postal Code:

Country:

Phone #:

Fax #:

Email:

Is this a residential address?

Employment Category: (Please Select)

Employment Status: (Please Select)

Practice Setting: (Please Select)

Role: (Please Select)

Patient Age Range: (Please Select)

Areas of Practice (select all that apply):

- Eye Glasses
- Contact Lenses
- Difficult Contact Lens Fittings
- Safety Glasses
- Low Vision Aids
- Artificial Eyes

Additional Practice Address(es) Business Name: Address: City: Province/Territory: Postal Code: Country: Phone #: Fax #: Email:	Employment Category: (Please Select) Employment Status: (Please Select) Practice Setting: (Please Select) Role: (Please Select) Patient Age Range: (Please Select)	Areas of Practice (select all that apply): Eye Glasses Contact Lenses Difficult Contact Lens Fittings Safety Glasses Low Vision Aids Artificial Eyes
Business Name: Address: City: Province/Territory: Postal Code: Country: Phone #: Fax #: Email:	Employment Category: (Please Select) Employment Status: (Please Select) Practice Setting: (Please Select) Role: (Please Select) Patient Age Range: (Please Select)	Areas of Practice (select all that apply): Eye Glasses Contact Lenses Difficult Contact Lens Fittings Safety Glasses Low Vision Aids Artificial Eyes

CONDUCT

i.	In the course of your post-secondary education, have allegations of misconduct, including academic misconduct, been made against you or have you been suspended, required to withdraw, expelled or otherwise penalized by an academic institution for misconduct?	Yes	No
ii.	Have you been found guilty of or have allegations of negligence or malpractice been made against you by a body that governs a profession inside or outside of Ontario?	Yes	No
iii.	Has a finding of professional misconduct or incompetence been made against you or have you been found to be incapacitated by a body that governs a profession inside or outside of Ontario?	Yes	No
iv.	Are you currently the subject of a proceeding for professional misconduct, incompetence or incapacity by a body that governs a profession, inside or outside of Ontario?	Yes	No
v.	Have you been refused registration by a body that governs a profession, inside or outside of Ontario?	Yes	No
vi.	Have you had your registration suspended or revoked by a body that governs a profession, inside or outside of Ontario?	Yes	No
vii.	Have you been charged with or found guilty of an offence, in Canada or any other jurisdiction?	Yes	No
viii.	Have you been subject to any bail conditions or other restrictions (imposed on or agreed to by you in connection with the charge)?	Yes	No
ix.	Do you currently have any physical or mental condition or disorder which may impair your ability to practise Opticianry safely and competently, or which, if left untreated, would impair your ability to practise Opticianry safely and competently?	Yes	No
x.	Have you at any time during the previous five years had any physical or mental condition which would have impaired your ability to practise Opticianry safely and competently, or which, if left untreated, would have impaired your ability to practise Opticianry safely and competently?	Yes	No

If "Yes" to any of the above questions, please provide a statement explaining the circumstances on a separate page. Please include your explanation, and any supporting documentation, with your application.

Effective January 1, 2021, applicants for a certificate of registration as a Registered Optician must provide a Vulnerable Sector check as part of their application for registration with the College. Have you attached a Vulnerable Sector check report conducted in Canada within the past six months? Yes No

DECLARATION

I _____ of the (Please Select) of _____ in the (Please Select) of _____ in the country of _____ hereby declare:

(Full Applicant Name) (City/Town/County) (Province/State) (Country)

1. I am the person making the application for a Certificate of Registration to practise Opticianry in Ontario and the application was completed and signed by me;
2. The photograph attached to the application is an unaltered photograph of me taken within six months from the date of this application;
3. I understand and agree that any address and email address I provided in the employment section of the application will be displayed on the Public Register;
4. I understand that I have an obligation to notify the College within 30 days if there are any changes to the information provided in this form; and,
5. I understand and agree that if I make a false or misleading statement or representation on this application or any of the Forms related to this application, or if I falsify any documents supporting my application, the application may be deemed invalid, and any registration resulting from the application may be subject to revocation and/or disciplinary proceedings.

_____
Applicant Signature

_____
Date

_____
Witness Signature

_____
Witness Name

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FORM A – DISPENSING EXPERIENCE VERIFICATION

Please fill in the information below if you graduated from a unaccredited program or an accredited program but your graduation letter does not verify your dispensing experience. You must complete 1000 hours of verified dispensing experience prior to applying for registration as a Registered Optician.

GENERAL INFORMATION

Last Name: First Name: Registration Number:

Email Address:

DISPENSING EXPERIENCE

Please provide the information below regarding your dispensing experience

Business Name:

Street Address: Phone #:

City: Fax #:

Province: Email:

Postal Code: First Day of Dispensing: / /

Country: Last Day of Dispensing*: / /

How many hours did you dispense per week at this practice location?

How many hours total have you dispensed at this practice location?

Number of eyeglass fittings (=>250)**:**

- Multi Focal (=>100)
- High Myopic (=>25**)
- Hyperopic (=>25**)

Number of contact lens fittings (=>20)**:**

- Soft
- Rigid Gas Permeable (=>5)

*not applicable if you are currently dispensing at this location

** You are required to have either 25 high myopic or 25 hyperopic fittings, or a combination of both

SUPERVISOR DECLARATION

This section should be completed by a Registered Optician, Optometrist, or Medical Doctor who supervised your dispensing*

I verify and confirm that the individual named above has dispensed under my supervision, and the information noted in this form is complete and accurate

Supervisor Name:	**Additional Supervisor Name (if applicable):**
Registration Number:	Registration Number:
Governing Body:	Governing Body:
Signature:_____	Signature: _____
Date:	Date:

* If your dispensing experience was completed outside of Canada, please provide a sworn affidavit stipulating you have completed the required 1000 hours of dispensing experience. The Affidavit must be sworn in the presence of a Commissioner of Oaths. Please see the College's website for a sample Affidavit.

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FORM B – CERTIFICATE OF STANDING

AUTHORIZATION FOR THE RELEASE OF INFORMATION

The following is to be completed by the applicant and forwarded to the regulatory authority with which the applicant is, or has been previously, registered. It is the applicant's responsibility to assume all costs related to the regulatory authority's provision of the information below.

I _____ have applied for a Certificate of Registration with the College of Opticians of Ontario in order to engage in the
(Applicant's Full Name)

practice of Opticianry. I hereby authorize _____ to release the information requested in this form,
(Regulatory Authority)

including any information related to my registration that may affect my suitability to practise Opticianry in Ontario.

I also hereby authorize _____ and the College of Opticians of Ontario to communicate directly with each other as
(Regulatory Authority)

necessary to clarify or verify information relating to my registration file.

_____ _____
Signature Date

The following is to be completed by the regulatory authority and returned to the College of Opticians of Ontario

GENERAL INFORMATION

Applicant's registered name:

Applicant's previous name(s):

The applicant is/was registered to practise as: ○ Optician ○ Optometrist ○ Ophthalmologist ○ other:_____

REGISTRATION HISTORY

Registration Type	***Registration Number***	***From*** *(mm/dd/yyyy)*	***To*** *(mm/dd/yyyy)*

To the best of your knowledge, has this applicant been registered in any other jurisdiction? ○ Yes* ○ No

If "Yes", please fill in the information in the table below

Governing Body	***From*** *(mm/dd/yyyy)*	***To*** *(mm/dd/yyyy)*

Has this applicant's registration/licence ever been suspended? ○ Yes* ○ No

If "Yes", please provide details:

Has this applicant's registration/licence ever been revoked? ○ Yes* ○ No

If "Yes", please provide details:

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PROFESSIONAL CONDUCT

Is this applicant's license/registration subject to any terms, conditions, limitations or restrictions? ○ Yes* ○ No

If "Yes", please provide details:

Has this applicant entered into any undertakings with respect to their license/registration? ○ Yes* ○ No

If "Yes", please provide details:

Is this applicant currently the subject of any professional misconduct, incompetency or incapacity proceeding? ○ Yes* ○ No

If "Yes", please provide details:

Has this applicant ever been the subject of a professional misconduct, incompetency or incapacity proceeding? ○ Yes* ○ No

If "Yes", please provide details:

Is this applicant currently the subject of a formal complaint or investigation? ○ Yes* ○ No

If "Yes", please provide details:

Has this applicant ever been the subject of a formal complaint or investigation where the outcome was anything other than "no further action"? ○ Yes* ○ No

If "Yes", please provide details:

Has this applicant ever been found to be non-compliant with your quality assurance and/or continuing education program? ○ Yes* ○ No

If "Yes", please provide details:

Does this applicant have any outstanding obligations to your organization (such as fees)? ○ Yes* ○ No

If "Yes", please provide details:

Is there any additional information that may be relevant to the applicant's suitability to practise Opticianry?

CERTIFICATION

I confirm that all the information provided in this form is complete and accurate

Regulatory Authority | Title | Date Signed and Sealed

Seal/Stamp:

Please forward the complete Certificate of Standing to the College of Opticians by email, fax, or mail

registration@collegeofopticians.ca

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FORM C – INSURANCE OR UNDERTAKING

Please fill in either the insurance information **OR** the undertaking portion of the form. Please note that if you are employed in the profession, or wish to maintain your status as "Entitled to Practise" on the public register, you must have professional liability insurance.

GENERAL INFORMATION

Last Name: First Name: Registration Number:

Email Address:

INSURANCE INFORMATION

Please provide the information below regarding your professional liability insurance.

Insurance Company Name:

Policy Number:

Certificate Number:

Professional Liability Coverage Amount:

Expiry Date:

Is this personal insurance, or is the insurance provided by your employer? ○ Personal ○ Employer*

*If professional liability insurance is provided by your employer:

- Your name must be listed on the insurance certificate; and
- You must have professional liability insurance for every business at which you are employed

Acknowledgement and Declaration

I _____ hereby declare:
(Full Name)

1. The insurance information contained in this form is complete and accurate;
2. I am insured under said policy;
3. I have provided a copy of the policy to the College along with this form as proof of my insurance;
4. Should my policy expire while I am employed in the profession, I undertake to renew or replace my policy prior to the expiry date in the amount of no less than $1,000,000, and submit a copy of the renewed policy to the College; and,
5. I understand and agree that making a false statement will be considered an act of professional misconduct and may result in revocation and/or disciplinary proceedings against me.

_____ _____
Signature Date

UNDERTAKING

Complete this section only if you are not employed in the practice of Opticianry and do not intend to be. Please note that completing this section will result in your status being displayed as "Not Entitled to Practise" on the Public Register.

I _____ (Full Name) hereby undertake to not engage in the practice of Opticianry, including the dispensing of eye glasses, contact lenses, and subnormal vision devices, nor to supervise or direct a student optician or a registered intern optician in Ontario, until I submit proof of my professional liability insurance to the College and my status has changed to "Entitled to Practise" on the public register. I understand and agree that a breach of this undertaking will be considered professional misconduct and may result in revocation and/or disciplinary proceedings against me.

_____ _____
Signature Date

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FORM D - CREDIT CARD AUTHORIZATION FORM

Please fill in the information below in order to authorize the College to charge your credit card for the amount required for the service requested.

Registration Number:

Last Name: First Name:

Email Address:

Amount to be Charged: Service Requested:

CREDIT CARD INFORMATION

Please provide your credit card information below:

☐ Visa ☐ Master Card ☐ American Express

Credit Card #: Expiry Date:

Cardholder Name:

Cardholder Signature: