

# Application for Reinstatement of a Certificate of Registration as an Optician



## PERSONAL INFORMATION

Registration #:	Salutation:	Legal First Name:
Legal Middle Name:	Legal Last Name:	
Home Address		Alternative Home Address
Address		Address
City		City
Prov./Terr./State		Prov./Terr./State
Postal Code/Zip Code		Postal Code/ Zip Code
Country		Country
Phone		Phone
Fax		Fax
Mobile		Email
Personal Email Address for College Communications:		

## PRACTICE INFORMATION

If you are employed in opticianry enter the address details for each location where you are employed below. If you are not employed or not in active opticianry practise you must supply a designated practice address; this address can be a P.O. Box number. Although, your home address is considered private information, if you are not practising or you are in private practice and designate your home address as your practice address, this will be shared on the Public Register.

Practise Status <i>(Please select only one)</i>	Primary Employment
<input type="checkbox"/> Employed in Opticianry (in any capacity) <input type="checkbox"/> Employed, on leave <i>(specify reason and date below)</i> <input type="checkbox"/> Unemployed and seeking employment in Opticianry <input type="checkbox"/> Unemployed and not seeking employment in opticianry <input type="checkbox"/> Working outside of the profession and seeking work in Opticianry <input type="checkbox"/> Working outside of the profession and not seeking work in Opticianry  Leave Reason :  Leave start date(dd/mm/yyyy):	Business Name
	Address
	City
	Prov./Terr./State
	Postal Code/Zip Code
	Country
	Intersection
	Plaza/Mall
	Phone
	Extension
	Fax
	Email
	Is this a residential address? <input type="checkbox"/> Yes <input type="checkbox"/> No

Secondary Employment	Tertiary Employment
Business Name	Business Name
Address	Address
City	City
Prov./Terr./State	Prov./Terr./State
Postal Code/ Zip Code	Postal Code/ Zip Code
Country	Country
Intersection	Intersection
Plaza/Mall	Plaza/Mall
Phone	Phone
Extension	Extension
Fax	Fax
Email	Email
Is this a residential address? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this a residential address? <input type="checkbox"/> Yes <input type="checkbox"/> No

# Application for Reinstatement of a Certificate of Registration as an Optician



## PRACTICE INFORMATION continued

### Preferred Work Status

What is your preferred work status in the profession of Opticianry  Full-Time  Part-Time  Casual

### Practise Hours/ Weeks: This is only applicable to registrants who were practising outside of Ontario in the past 12 months.

Practise Hours/ Weeks	Number of weeks you spent practising in opticianry the past 12 months across all of your practice sites or jobs?	Number of Weeks ▶
	Average number of hours spent practising in opticianry per week in the past 12 months across all of your practice sites or jobs?	Average Number of Hours ▶
	Average number of on-call hours per week you spent practising in opticianry in the past 12 months across all of your all practice sites or jobs?	Average Number of On-Call Hours ▶

If you have obtained employment as an optician in any capacity complete the employment information below for each location where you are currently employed as an optician.

### Proportion of Weekly Practice Hours: (The total should reflect the percentage of the total hours across all employers and must equal 100%)

Direct Professional Services: ____%	Teaching: ____%	Research: ____%	Administration: ____%	Other Activities: ____%	Total: 100%
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### Employment Category

Primary Employment <input type="checkbox"/> <input type="checkbox"/>	Secondary Employment <input type="checkbox"/> <input type="checkbox"/>	Tertiary Employment <input type="checkbox"/> <input type="checkbox"/>
01 Permanent	02 Temporary/Contract	03 Casual
		04 Self-Employed

### Employment Status

Primary Employment <input type="checkbox"/> <input type="checkbox"/>	Secondary Employment <input type="checkbox"/> <input type="checkbox"/>	Tertiary Employment <input type="checkbox"/> <input type="checkbox"/>
01 Full-time	02 Part-time	03 Casual (no fixed hours)

### Position

Primary Employment <input type="checkbox"/> <input type="checkbox"/>	Secondary Employment <input type="checkbox"/> <input type="checkbox"/>	Tertiary Employment <input type="checkbox"/> <input type="checkbox"/>
01 Administrator	04 Manager	07 Salesperson
02 Consultant	05 Owner/Operator	08 Service Provider (i.e. Dispensing; conducting the controlled act of the profession)
03 Instructor/Educator	06 Researcher	09 Quality Management Specialist
		10 Other (Specify)

### Employment Service(s)

Primary Employment <input type="checkbox"/> <input type="checkbox"/>	Secondary Employment <input type="checkbox"/> <input type="checkbox"/>	Tertiary Employment <input type="checkbox"/> <input type="checkbox"/>
01 Administration	04 Other Area of Direct Service/ Consultation	07 Research
02 Consultation	05 Post-Secondary Education	08 Sales
03 General Service Provision	06 Quality Management	09 Other area not Identified (Specify)

### Areas of Practise

Primary Employment	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Secondary Employment	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	Tertiary Employment	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
01 Artificial Eyes	02 Both Eyeglasses and Contact Lenses	03 Contact Lenses ONLY	04 Difficult Contact Lens Fittings	05 Eyeglasses Only	06 Geriatrics	07 Low Vision Aids	08 Mobile Services	09 Paediatrics	10 Refraction (Registered Refracting RO's Only)	11 Safety Glasses	12 Other Area of Practice (Specify)	

# Application for Reinstatement of a Certificate of Registration as an Optician



## PRACTICE INFORMATION continued

### Patient Age Range

Primary Employment	<input type="checkbox"/> <input type="checkbox"/>	Secondary Employment	<input type="checkbox"/> <input type="checkbox"/>	Tertiary Employment	<input type="checkbox"/> <input type="checkbox"/>
01 Preschool age (0-4)		04 Adults (18-64)		07 All Ages	
02 School age (5-17)		05 Seniors (65+)		08 Other Patient Age Range (Specify)	
03 Mixed Paediatrics (0-17)		06 Mixed Adults (18-65+)		09 Not Applicable	

### Practice Setting

Primary Employment	<input type="checkbox"/> <input type="checkbox"/>	Secondary Employment	<input type="checkbox"/> <input type="checkbox"/>	Tertiary Employment	<input type="checkbox"/> <input type="checkbox"/>
01 Association/ Government/ Regulatory Organization/ Non-Government Organization		06 Independent Health Facility		10 Other Group Practice Office	
02 Board of Health or Public Health Laboratory or Public Health Unit		07 Ophthalmologist Office		11 Other Laboratory Facility	
03 Post-Secondary Educational Institution		08 Optical Dispensary		12 Patient's Environment	
04 Health Related Business Industry		09 Optometrist Office		13 Solo Practice Office	
05 Hospital				14 Other Practice Setting ( <i>Specify</i> )	

## CONCURRENT REGISTRATION/ RECENT PRACTISE

Provide the information requested below for all your concurrent registration locations (i.e. inside or outside of Ontario).

### a. Concurrent Registration Location:

Regulatory / Licensing Body	Province/ Territory/ State	Country	Licence/ Registration Number	Expiry Date mm//dd//yyyy	In good standing
1.					<input type="checkbox"/> Yes <input type="checkbox"/> No
2.					<input type="checkbox"/> Yes <input type="checkbox"/> No
3.					<input type="checkbox"/> Yes <input type="checkbox"/> No

If you are not in good standing in any of your current or previous registration /license locations provide details and reason(s) on a separate sheet of paper and submit to the College along with this form.

### b. Recent Practise History : If you have recently practised opticianry outside of Ontario provide the information below.

Country:	Province/ Territory/ State:	Date Last Practiced outside of Ontario:
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## EDUCATION

a. Opticianry Education: Provide the information requested below If you have completed additional opticianry education since last reporting to the College. .  
*Documentary proof of completed education required.*

Level of Education	Name of School/ Educational Institution	Program Name	Province/State/ Territory	Country	Date of Graduation mm//dd//yyyy
1. D					
2.					
3.					
4.					
5.					

Level of Education  
10 Diploma

20 Certificate (E.g. NAIT: Optical Sciences Contact Lenses)

30 Post Diploma Certificate (E.g. Refraction Certificate)

40 None of the above (*Specify*)

# Application for Reinstatement of a Certificate of Registration as an Optician



## EDUCATION continued

**b. Education other than Opticianry:** Provide the information requested below If you have completed additional education (i.e. other than opticianry) since last reporting to the College. *Documentary proof of completed education required.*

Level of Education	Field of Study	Name of School/Educational Institution	Program Name.	Prov./State/Terr.	Country	Date of Graduation mm//dd//yyyy
1. <input type="text"/>	<input type="text"/>					
2. <input type="text"/>	<input type="text"/>					
3. <input type="text"/>	<input type="text"/>					
4. <input type="text"/>	<input type="text"/>					
5. <input type="text"/>	<input type="text"/>					

### Level of Education

- 01 Diploma
- 02 Baccalaureate
- 03 Master's Degree
- 04 Professional Doctorate
- 05 Doctorate
- 06 None of the Above
- 07 Entry to Practice Post Diploma Certificate/Courses

### Field of Study

- 01 Biological and Biomedical Sciences
- 02 Business, Management, Marketing and Related
- 03 Education
- 04 Engineering
- 05 General Rehabilitation Science
- 06 Gerontology
- 07 Health Administration/ Management
- 08 Health Professions and Related Clinical Services
- 09 Kinesiology and Exercise Science
- 10 Law
- 11 Mathematics, Computer Information Sciences
- 12 Medical Laboratory Science
- 13 Physical Sciences
- 14 Public Administration
- 15 Public Health
- 16 Psychology
- 17 Social Sciences, Arts and Humanities
- 18 Other Field of Study (*Specify*)

## CITIZENSHIP/ IMMIGRATION STATUS

Are you a Canadian Citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you do not hold Canadian citizenship, are you a permanent resident of Canada?	<input type="checkbox"/> Yes <input type="checkbox"/> No      Expiry date: mm//dd//yyyy
If you are not a permanent resident/ landed immigrant of Canada, do you hold a valid work permit to be employed in Canada?	<input type="checkbox"/> Yes <input type="checkbox"/> No      Expiry date: mm//dd//yyyy

## CONDUCT

Have you ever been found guilty of an offense related to the regulation of the practice of Opticianry that has not been previously reported to the College?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been found guilty of a criminal offense that has not been previously reported to the College?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has a finding of professional negligence or malpractice, which may or may not relate to your suitability to practice, been made against you that has not been previously reported to the College?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been refused registration in an Opticianry regulatory body that has not been previously reported to the College?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a finding of or are you currently facing a proceeding for professional misconduct, incompetency, incapacity, or a similar issue <u>in relation to Opticianry</u> in Ontario or another jurisdiction that has not been previously reported to the College?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a finding of, or are you currently facing a proceeding for professional misconduct, incompetency, incapacity or a similar issue in another profession other than opticianry in Ontario or elsewhere, that has not been previously reported to the College?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you have answered 'YES' to any of the questions above, please provide full details including any relevant documentation. For further guidance, please also [click here](#) to refer to the Registration Policy dealing with 'Convictions, Findings and Ongoing Proceedings'.

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## COMBINED REINSTATEMENT & RENEWAL FEE

Amount to be paid:  \$ 1235.09 (Includes: Annual Registration Fee of \$ 1093.84 + Reinstatement Fee of \$141.25 (all fees includes 13%HST)).

Method of Payment: *(select payment method)*

Visa

MasterCard

Credit Card Number (16 digits)

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Expiry Date (4 digits)

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Cardholder's Name

Cardholder's Signature

## SIGNATURE AND DECLARATION

I hereby apply for reinstatement (lifting of suspension) of my Certificate of Registration (certificate) as a Registered Optician and certify that the statements made by me on this form are complete and correct to the best of my knowledge and belief. I understand that a false or misleading statement or the falsification or tampering of any documentation hereby submitted may result in professional misconduct proceedings being brought against me, may disqualify me from reinstatement of my certificate, or may be cause for revocation of any registration which may be granted to me. I understand that my reinstatement fees will be processed upon receipt but that this does not imply that my application has been approved. I confirm that any photos I have submitted are a true likeness of me.

I understand that, in accordance with article 15 of the College of Opticians of Ontario's By-laws, should I provide my home address as my place of business or as my "designated address", my home address will be made publicly available on the College's Public Register. Should I feel that this would jeopardize my personal safety, I understand that I need to make a request, in writing, to the Registrar to have this information removed from the Public Register. I also understand that it is a requirement of the Opticianry Act and its regulations that I notify the College, in writing, of any change in my legal name, home or business information within thirty (30) days of the change.

Signature:

Date:

## GENERAL INSTRUCTIONS

### BEFORE SUBMITTING THIS APPLICATION FORM, PLEASE ENSURE THAT:

- Your name and contact information are filled in clearly and legibly;
- You have included a passport-style photograph which provides a clear, coloured image of your head and shoulders against a white background. If you are mailing your application, the photograph must also be signed at the back;
- You have included the correct credit card information;
- You have included a completed Certificate of Being Insured Under a Professional Liability Insurance Policy Form (COBI) or Undertaking Form (if not intending to dispense once reinstated);
- If applicable, you have included proof of education completed inside or outside of Ontario;
- If applicable, you have included details of any conduct disclosures that have not been previously reported to the College;
- If there is a change in your immigration status you have submitted documentary proof of that change;

Please email or fax this form and all required documentation to:

The College of Opticians of Ontario  
90 Adelaide St West, Suite 300  
Toronto, ON M5H 3V9

Fax: 416-368-2713 OR Tel: 1-800-990-9698

Email: [registration@collegeofopticians.ca](mailto:registration@collegeofopticians.ca)

## CERTIFICATE OF BEING INSURED UNDER A PROFESSIONAL LIABILITY INSURANCE POLICY FORM 2020

**IF YOU DO NOT HAVE PROFESSIONAL LIABILITY INSURANCE PLEASE COMPLETE THE "UNDERTAKING" FORM**

This form is fillable. Please PRINT all information clearly if you are not filling out this form electronically. All required information is marked with an asterisk (\*). Please complete all sections below. The College understands the importance of protecting personal information. 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.

### A. Personal Information

		Registration Number:
* First Name:	Middle Name:	* Last Name:

### B. Policy Details

* Name of Insurance Company:	* Policy number:
* Policy amount:	* Does the policy state "Professional Liability Insurance" <input type="checkbox"/> Yes <input type="checkbox"/> No If 'No' Identify the type of insurance policy:

### C. Optician Acknowledgement

\* I understand and acknowledge that making a false statement may be considered an act of professional misconduct for the purposes of clause 51(1)(C) of the Health Professions Procedural Code  Yes  No

### D. Optician Declaration and Signature

\* I \_\_\_\_\_ hereby certify that I am insured under the insurance policy indicated in this form, with a professional liability amount of no less than \$1,000,000. Further, should said 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.

* Optician Signature:	* Date:
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\* Signed at (Location/ including province or country):

**\* Please provide a copy of your professional liability insurance along with this completed form**

**Please fax or email this form to:**

The College of Opticians of Ontario  
90 Adelaide Street West, Suite 300  
Toronto, ON M5H 3V9  
Fax: 416-368-2713 OR Tel: 1-800-990-9698  
Email: [registration@collegeofopticians.ca](mailto:registration@collegeofopticians.ca)

## UNDERTAKING FORM 2020

**IF YOU HAVE PROFESSIONAL LIABILITY INSURANCE DO NOT COMPLETE THIS FORM – COMPLETE A CERTIFICATE OF BEING INSURED UNDER PROFESSIONAL LIABILITY INSURANCE POLICY FORM**

This form is fillable online. Please PRINT all information clearly if you are not filling out this form electronically. All required information is marked with an asterisk (\*). Please complete all sections below. The College understands the importance of protecting personal information. 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.

A. Personal Information		
		Registration Number:
* First Name:	Middle Name:	* Last Name:
B. Optician Declaration and Signature		
<p>* I _____ (print name or insert signature) hereby undertake to the College of Opticians of Ontario (the "College") that I will NOT engage in the practice of opticianry, including the dispensing of Eye Glasses, Contact Lenses, and Subnormal Vision Devices and the supervision or direction of a registered or non-registered student optician or a registered intern optician, in Ontario, until I submit proof of professional liability insurance to the College. I understand that a breach of this undertaking shall be considered an act of professional misconduct for the purposes of clause 51(1) (C) of the Health Professions Procedural Code. I agree that this undertaking will appear on the Public Register.</p>		
* Optician Signature:	* Date:	
* Signed at (Location/ including province or country):		

**PLEASE NOTE: This undertaking is only valid for the current application year or once proof of professional liability insurance is submitted to the College.**

**Please fax or e-mail this form to:**  
 The College of Opticians of Ontario  
 90 Adelaide Street West, Suite 300  
 Toronto, ON M5H 3V9  
 Fax: 416-368-2713 OR Tel: 1-800-990-9698  
 Email: registration@collegeofopticians.ca