



# The College of Optometrists of Ontario

## Application for Funding for Therapy and Counselling

**Applicant's Name** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Name of Optometrist:** \_\_\_\_\_

Date of Finding by the Discipline Committee: \_\_\_\_\_ **OR**

Date of Finding by a Court of Competent Jurisdiction: \_\_\_\_\_

Name of Counsellor: \_\_\_\_\_

Office Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Is this counsellor a Regulated Health Professional: **No** \_\_\_\_\_ **Don't Know** \_\_\_\_\_ **Yes** \_\_\_\_\_

If **YES**, name of College with which is the counsellor registered: \_\_\_\_\_

Are the services of this counsellor covered by OHIP or any other insurer: \_\_\_\_\_ **Don't Know** \_\_\_\_\_ **No**

**Yes - please provide details** \_\_\_\_\_

Have you already attended therapy or counselling for this matter? \_\_\_\_\_ **Yes** - Date when therapy

or counselling was started \_\_\_\_\_ *(attach copies of all invoices paid by you)*

\_\_\_\_\_ **No** - Expected date therapy or counselling will start \_\_\_\_\_

### Consent to Release Information

*I agree to allow the College of Optometrists of Ontario to contact the above named counsellor, as necessary to process this application for funding.*

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_