PRACTICE LOCATION/ CHANGE OF INFORMATION FORM
COLLEGE OF OPTOMETRISTS OF ONTARIO

65 St. Clair Ave. E., Suite 900, Toronto, Ont. M4T 2Y3 **Phone: 416 962 4071 Fax: 416 962 4073**

Name of Optometrist _____ **Registration #** _____

Primary Office

Please complete all questions

Address: ……..

City: ……. Province: …….

Postal Code: …… County: ……..

Country: …… Starting Date: ……
mm/dd/yyyy

Phone: (……) …… Fax: (……) ……..,….

Your days at this location:
- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday
- ☐ Saturday
- ☐ Sunday

Employment relationship:
- ☐ Permanent
- ☐ Temporary
- ☐ Casual
- ☐ Self-employed

Employment Status:
- ☐ Full-time
- ☐ Part-time
- ☐ Casual

Primary Role:
- ☐ Owner/Operator
- ☐ Service Provider (e.g. Associate)
- ☐ Administrator
- ☐ Consultant
- ☐ Instructor/Educator
- ☐ Manager
- ☐ Quality Management Specialist
- ☐ Salesperson
- ☐ Researcher

Client Age Range:
- ☐ Paediatrics (under 18 years)
- ☐ Adults
- ☐ Seniors (65 years and up)
- ☐ All ages
- ☐ Not applicable

Practice Setting:
- ☐ Solo Practice Office
- ☐ Group Practice Office
- ☐ Hospital
- ☐ Rehabilitation Facility
- ☐ Residential/Long-term Care Facility
- ☐ Client's Environment
- ☐ Community Health Centre
- ☐ Family Health Team
- ☐ Independent Health Facility
- ☐ Assisted Living Residence/Supportive Housing
- ☐ Group Health Centre
- ☐ Nurse Practitioner Led Clinic
- ☐ Post-secondary Educational Institution
- ☐ Children Treatment Centre
- ☐ Mobile Imaging Centre
- ☐ Other Place of Work
- ☐ Association/Government/Regulatory Org./Non-Government Org.

Services provided at this location:
- ☐ ADP Authorizer
- ☐ Automated Visual Fields
- ☐ Binocular Vision training
- ☐ Contact Lens Therapy
- ☐ Corneal Topography
- ☐ Digital Retinal Imaging
- ☐ Home Visits
- ☐ Infant Examinations (0 – 24 months)
- ☐ Institution Visits
- ☐ Low Vision Therapy
- ☐ Occupational Safety Eyeware
- ☐ Optical Coherence Tomography/Retinal Tomography
- ☐ Orthokeratology
- ☐ Pre-School Children (2 – 5 years)
- ☐ Punctal Occlusion
- ☐ Refractive Surgery Co-management
- ☐ Spectacle Therapy
- ☐ Sports Vision
- ☐ Visual Perception Testing and Therapy
- ☐ Wheelchair Access (to premises)
- ☐ Wheelchair Accessible Eye Exams

List of Names of regulated health professionals with whom you are associated, in partnership or otherwise?

…… ……

…… ……

Please complete all questions Name:_____ Registration #: _____

Second Office

Address: ……..

City: ……. Province: …….

Postal Code: …… County: …….

Country: …… Starting Date: ……
mm/dd/yyyy

Phone: (……) …… Fax: (……) ……..,….

Your days at this location:
☐ Monday
☐ Tuesday
☐ Wednesday
☐ Thursday
☐ Friday
☐ Saturday
☐ Sunday

Employment relationship:
☐ Permanent
☐ Temporary
☐ Casual
☐ Self-employed

Employment Status:
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☐ Part-time
☐ Casual

Primary Role:
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☐ Wheelchair Accessible Eye Exams

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Please complete all questions Name:_____ Registration #: _____

Third Office

Address: ……..

City: ……. Province: …….

Postal Code: …… County: …….

Country: …… Starting Date: ……
mm/dd/yyyy

Phone: (……) …… Fax: (……) ……..,….

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☐ Tuesday
☐ Wednesday
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☐ Friday
☐ Saturday
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Employment relationship:
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