



ALBERTA college
of OPTOMETRISTS
#102, 8407 Argyll Road NW
Edmonton, AB T6C 4B2

APPLICATION FOR A PRACTICE PERMIT 2010

Please complete the information listed below and return to the ACO office along with the remittance of the appropriate annual membership fee.

- 2010 Active Regulated Membership Fee = \$1000.00
- 2010 Courtesy Membership Fee = \$1000.00
- 2010 New Grad Registered Membership Fee = \$500.00
[First year of practice in Alberta annual fee reduced by ½]

Note* Section 15(1) of the Optometrists Profession Regulation requires all regulated members to obtain 60 continuing education credits and have a minimum of 150 days in practice in the Province of Alberta in every three year competency period. Your three competency period starts on the January 01 immediately following your registration with the Alberta College of Optometrists.

[*ACO Office Use Only*]

ACO Registration No. _____ (assigned by ACO office) Date:

Initial Year of Registration: _____ Base CE Year:

Registrant Status: (r/c):_____	College	Fee:

TPA [y/n] _____	CPR [y/n] _____	
Authorized for Restricted Activities:	[] Yes	[]
No		
Restriction:		

[Please PRINT]

PERSONAL INFORMATION:

Surname: _____ First Name:

Middle Name: _____

Preferred Name or Nickname if different than First Name:

Birthdate: _____/_____/_____ Gender:
F [] M []
Month Day Year

Spouse's First Name: _____ Last Name:

Home Address:

Home Telephone No.: ([Postal Code])

Personal E-Mail Address:

24 Hour Emergency Telephone Number. (Home number or other telephone number where patients can reach you in case of a patient emergency:

() -----

Fluent in What Additional Languages Others than English:

PRACTICE INFORMATION

MAIN PRACTICE ADDRESS:

Practice Name:

Street Address:

City/Town: _____ Province:

_____ Postal Code: _____

Tel No.: () _____ Fax No.: ()

E-Mail Address:

Website

Address:

Days per week in office: Mon Tues Wed Thurs
 Fri Sat Sun

(Please check each day of the week you are practicing in the above office)

DESIRED MAILING ADDRESS (if other than main office address above)

[Postal Code]

Satellite Office Address:

[1]-----

[Postal

Code]

Telephone No.: () ----- Fax No.: ()

Actual day(s) of the week in this office location:

[2]-----

[Postal

Code]

Telephone No.: () ----- Fax No.: ()

Actual day(s) of the week in this office location:

[If you have additional satellite offices, please list on a separate page with the same information as above.]

Additional Practice Information (Please check all that may apply)

Is this a group practice? Yes No
Is this a solo practice? Yes No
Is this a partnership? Yes No
Are you an associate? Yes No
Are you an employee? Yes No If yes,
salary or contract .
Do you practice? Full time Part time

Do you personally practice under your employer's professional corporation (PC)?

Yes No

If yes, PC Name is:

Please list all special interest areas of practice along with additional didactic and/or residency training:

Employment Information

Employer's Name:

Employer's Address:

[Postal Code]
Employer's Business Name (i.e. Trade Name or Practice Name):

Date of Employment:

Membership in Other Jurisdictions

Names of other jurisdictions in which you are a registered member:

Are you a member of any other professional college that provides health services?

[] Yes [] No.
If yes, what College or Profession?

Are you a practicing member of that College? [] Yes []
No

LIABILITY INSURANCE MAINTAINED:

(Insurance Name) _____ Company _____

Expiry Date of Policy: _____ Amount of Insurance: \$ _____

[It is vital that this information is provided to the ACO office. The ACO Council requires that all regulated members maintain a minimum of \$2,000,000.00 liability insurance. The onus is on the practitioner to provide this information on this form. A practice permit **will not be issued** until this requirement is complied with.]

Signature: _____
_____, O.D.

Date: _____