



#102, 8407 Argyll Road NW Edmonton, AB T6C 4B2  
Tel: (780)466-5999 Fax: (780)466-5969

## EXTERN APPLICATION FORM

[Please print or type]

Name of Applicant: \_\_\_\_\_

Home Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Tel. No.: [ ] \_\_\_\_\_ email \_\_\_\_\_

Date of Birth: \_\_\_\_\_

School of Optometry Sponsoring Externship: \_\_\_\_\_

Is the student covered under the School of Optometry's global insurance coverage - yes [ ] no [ ]

Has the student ever tested positive for HIV, Hepatitis B or Hepatitis C - yes [ ] no [ ]

Address of Main Office of Supervising Optometrist:

\_\_\_\_\_

Postal Code: \_\_\_\_\_

Tel. No.: [ ] \_\_\_\_\_ Fax No.: [ ] \_\_\_\_\_

Satellite Office Location(s)

1. \_\_\_\_\_

Postal Code: \_\_\_\_\_

Tel. No.: [ ] \_\_\_\_\_ Fax No.: [ ] \_\_\_\_\_

2. \_\_\_\_\_

Postal Code: \_\_\_\_\_

Tel. No.: [ ] \_\_\_\_\_ Fax No. [ ] \_\_\_\_\_

Liability Insurance: \_\_\_\_\_

[Underwriter]

[expiry date of policy]

[amt. of insurance]

Term of Externship Program: From: \_\_\_\_\_ To: \_\_\_\_\_

Name of Supervising Optometrist: \_\_\_\_\_

Signed: \_\_\_\_\_ [Applicant]

\_\_\_\_\_ [Supervising Optometrist]

Authorized Signature from School of Optometry:

\_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

[Please forward to the Alberta College of Optometrists to the mailing address or fax listed above]