Continuing Education Activity Accreditation Request Form

Please PRINT all information clearly if you are not filling out this form electronically. 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. Please complete all sections below.

A. Provider Information

	Name of Organization
Name	Position

Street Number	Street Name	Unit / Suite Number

P.O. Box	City	Province	Postal Code

Phone	Fax	Email

B. Activity Submission Information – *Supporting documentation may be required*

Exact Title of Activity Submitted	Is this Presentation Available to all Ontario Opticians? ☐ Yes ☐ No

Type of Activity	Level of Knowledge and Skill Required by Opticians who Attend
☐ Live Presentation ☐ Distance Learning / Online ☐ Scholastic / Institution-Based	☐ Entry-Level ☐ Advanced ☐ Intermediate ☐ Refracting Optician

Date(s) of Activity	
	Length of Activity

Speaker Name(s)

1. Full Name ____________________________ Title/Position __________________________________
2. Full Name ____________________________ Title/Position __________________________________
3. Full Name ____________________________ Title/Position __________________________________

***** Please enclose a short biography or CV specifying the professional designation and or title, education and affiliation of each speaker. If you require more space than provided above, please attach additional sheets of paper to this form***

C. Location(s) of Activity – if applicable

	Name of Venue

Street Number	Street Name	Unit / Suite Number

P.O. Box	City	Province	Postal Code

Phone	Fax	Email

This form has two (2) pages. Please complete BOTH pages before submitting to the College of Opticians of Ontario

D. Learning Outcomes of Activity

Please describe, in detail, the specific learning outcomes of the submitted activity (skills, activities or items of information) which attendees will be expected to incorporate into their professional duties

E. Signature

Signature ______________________________ Date ______________________________

F. Payment Information

Please Indicate the Requested Review Type

☐ **$16.15** **Standard Accreditation Review** (submitted a minimum of 45 days prior to the scheduled event)

☐ **$161.43** **Rush Accreditation Review** (submitted less than 45 days prior to the scheduled event)

Method of Payment

☐ Cheque (must be submitted with this form)

☐ Money Order (must be submitted with this form)

☐ Credit Card (VISA or MASTERCARD only)

G. Credit Card Authorization – to be completed ONLY if using this method of payment

Last name *(if different from that In Section A)*	First Name (*if different from that In Section A)*
Type of Credit Card ☐ VISA ☐ MASTERCARD	Total Amount to be Charged
Card Number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐	
Exp. Date ☐☐ / ☐☐	Signature for Authorization of Payment

BEFORE MAILING THIS FORM, PLEASE ENSURE THAT

☐ You have completed all applicable sections of this form, including learning outcomes (section D)

☐ You have included all supporting documentation such as bios, powerpoint presentations and slides

☐ You have dated and signed section E

☐ You have included the ***correct payment amount*** by either cheque, money order or credit card

☐ If you are paying by credit card, that you have included your card number, expiry date and ***SIGNATURE*** (we cannot process your payment without these)

Please mail this application to:
The College of Opticians of Ontario
85 Richmond Street West, Suite 902
Toronto, ON M5H 2C9

For Office Use Only – DO NOT WRITE IN THIS AREA			
Date Received	INT	Date Charged	INT
Date Mailed	INT	Tracking Number (if applicable)	

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