

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. CE Activity Submission Information – Supporting Documentation Required

Exact Title of CE Activity Submitted	Is This CE Activity Available to all Ontario Opticians? <input type="checkbox"/> Yes <input type="checkbox"/> No
Type of CE Activity <input type="checkbox"/> Live Presentation <input type="checkbox"/> Distance Learning / Online <input type="checkbox"/> Scholastic / Institution-Based	Level of Knowledge and Skill Required by Participants <input type="checkbox"/> Entry-Level <input type="checkbox"/> Advanced <input type="checkbox"/> Intermediate <input type="checkbox"/> Refracting Optician
Date(s) of CE Activity	Is this a Previously Accredited CE Activity? <input type="checkbox"/> Yes <input type="checkbox"/> No
Length of CE Activity	If 'Yes' was selected, please specify the CE Activity ID# assigned by the COO

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 CE Activity – if applicable

Name of Venue			
Street Number	Street Name		Unit / Suite Number
P.O. Box	City	Province	Postal Code
Phone	Fax	Email	

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

- \$84.75 Standard Accreditation Review** (submitted more than (45) days prior to the scheduled event)
- \$226.00 Fast Track Accreditation Review** (submitted between (45) to (10) days prior to the scheduled event)
- \$565.00 Rush Accreditation Review** (submitted less than (10) days prior to the scheduled event)
- \$28.25 CE Activity Accreditation Renewal** (limit of (1) renewal per previously accredited CE activity)

****All fees include applicable taxes (HST)**

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Exp. Date

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
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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)	