

ADDRESS CHANGE FORM

Please PRINT all information clearly if you are mailing this form. If you are a Registered Optician and are submitting a change of business address you are required to submit an updated Certificate of Being Insured (COBI) to the College. If you are not currently employed or self-employed or working from home you must designate an address as your employment address; this address can be a P.O. Box number with a contact phone number so that the College or a member of the public can be reasonably certain of reaching you. Although your home address is considered private information, if you designate your home address as your employment address, this will be shared on the Public Register.

All required information is marked with an *.

A. Personal Information			
*Registration Number		*Last Name:	
*First Name:		Middle Name:	
*Preferred Mailing Address: <input type="checkbox"/> Home <input type="checkbox"/> Business		Personal Email Address for College Communications:	
B. New Mailing Address			
*Address:		*City:	
Prov./Terr./State:	*Postal Code/P.O. Box:	*Country:	
*Phone:	Cell:	Fax:	
Effective Date:(yyyy/mm//dd)			
C. Alternate Mailing Address			
*Address:		*City:	
Prov./Terr./State:	*Postal Code/P.O. Box:	*Country:	
*Phone:	Cell:	Fax:	
Effective Date:(yyyy/mm//dd)			
D. New Employment Address- <i>*Supporting Documentation Required</i>			
*Business Name:		*Address:	
*City	Prov./Terr./State:	*Postal Code/P.O. Box:	
*Country:	*Phone:	Extension:	
Fax:		*Is this a designated employment address? <input type="checkbox"/> Yes <input type="checkbox"/> No	
*Are you currently dispensing? <input type="checkbox"/> Yes <input type="checkbox"/> No		Effective Date:(yyyy/mm//dd)	
E. Alternate Employment Address			
*Business Name:		*Address:	
*City:	Prov./Terr./State:	*Postal Code/P.O. Box:	
*Country:	*Phone:	Extension:	
Fax:		Effective Date:(yyyy/mm//dd)	

***Supporting Documentation:**

If you are a registered optician and you are updating your employment address and you will be/are dispensing, in addition to completion and submission of this form you must also submit a [Certificate of Being Insured \(Under a Professional Liability Insurance Policy\) Form](#). Your status with the College will then be recorded as Current and Active in the Public Register of Members. If your work does not involve dispensing or you do not have Professional Liability Insurance Coverage you must submit an [Undertaking Form](#). Your status with the College will be recorded as Current and Inactive in the Public Register of Members.

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

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F. Employment Profile Information

If you are updating your employment address you **must** complete the information requested below for your primary and secondary employer (if applicable).
Write corresponding code in the box

*Employment Category:		*Practice Setting:	
Primary Address <input type="checkbox"/> <input type="checkbox"/>	Secondary Address <input type="checkbox"/> <input type="checkbox"/>	Primary Address <input type="checkbox"/> <input type="checkbox"/>	Secondary Address <input type="checkbox"/> <input type="checkbox"/>
01 Permanent 02 Temporary/Contract	03 Casual 04 Self-Employed	01 Association/ Government/ Regulatory Organization/ Non- Government Organization 02 Board of Health or Public Health Laboratory or Public Health Unit 03 Post-Secondary Educational Institution 04 Health Related Business Industry	05 Hospital 06 Independent Health Facility 07 Ophthalmologist Office 08 Optical Dispensary 09 Optometrist Office 10 Other Group Practice Office 11 Other Practice Setting 12 Other Laboratory Facility 13 Patient's Environment 14 Solo Practice Office
*Employment Status:		*Areas of Practice:	
Primary Address <input type="checkbox"/> <input type="checkbox"/>	Secondary Address <input type="checkbox"/> <input type="checkbox"/>	Primary Address <input type="checkbox"/> <input type="checkbox"/>	Secondary Address <input type="checkbox"/> <input type="checkbox"/>
01 Full-Time 02 Part-Time	03 Casual (no fixed hours)		01 Artificial Eyes 02 Both Eyeglasses and Contact Lenses 03 Contact Lenses ONLY 04 Difficult Contact Lens Fittings 05 Eyeglasses Only 06 Geriatrics 07 Low Vision Aids 08 Mobile Services 09 Paediatrics 10 Refraction (RO's Only) 11 Safety Glasses 12 Other Area of Practice
*Position:		*Employment Services(s):	
Primary Address <input type="checkbox"/> <input type="checkbox"/>	Secondary Address <input type="checkbox"/> <input type="checkbox"/>	Primary Address <input type="checkbox"/> <input type="checkbox"/>	Secondary Address <input type="checkbox"/> <input type="checkbox"/>
01 Administrator 02 Consultant (RO's Only) 03 Instructor/Educator (RO's Only) 04 Manager 05 Owner/Operator	06 Researcher 07 Salesperson 08 Service Provider 09 Quality Management Specialist 10 Other		01 Administration 02 Consultation (RO's Only) 03 General Service Provision 04 Other Area of Direct Service/ Consultation 05 Post-Secondary Education (RO's Only) 06 Quality Management 07 Research 08 Sales 09 Other area not Identified
*Patient Age Range:		*Employment Services(s):	
Primary Address <input type="checkbox"/> <input type="checkbox"/>	Secondary Address <input type="checkbox"/> <input type="checkbox"/>	Primary Address <input type="checkbox"/> <input type="checkbox"/>	Secondary Address <input type="checkbox"/> <input type="checkbox"/>
01 Preschool age (0-4) 02 School age (5-17) 03 Mixed Paediatrics (0-17) 04 Adults (18-64) 05 Seniors (65+)	06 Mixed Adults (18-65+) 07 Other Patient Age Range 08 Not Applicable 09 All Ages		

F. Signature

Signature:

Date:

FOR OFFICE USE ONLY – Do not write in this area

Date Received:

Date Changed:

Int:

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