ALBERTA college of OPTOMETRISTS

#102, 8407 Argyll Road NW
Edmonton, AB T6C 4B2

APPLICATION FOR A PRACTICE PERMIT

Please complete the information listed below and return to the ACO office along with the remittance of the appropriate annual membership fee. Please contact the ACO office for current membership fees (780-466-5999 or 1-800-668-2694).

[ ] Active Regulated Membership Fee - $1,100.00

[ ] Courtesy Membership Fee - $1,100.00

[ ] New Grad Registered Membership Fee - $550.00
[If you register in the same year as your graduation from Optometry School; or, in the same year that you complete a Residency Program, the annual ACO membership fee is reduced by ½]

Note* **All Regulated Members must obtain a minimum of 150 continuing education credits and have a minimum of 750 hours in practice in the Province of Alberta in every three year competency period.**

[*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 Advanced Scope 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: _____

_____
[Postal Code]

Home Telephone No.: ( ) _____

Preferred 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.: ( ) _____

Office E-Mail 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 home address)

_____

_____

[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)

Who will be custodian of your patient files? _____

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

(Insurance Company Name)_____

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: _____