ALBERTA college of OPTOMETRISTS

Application for Funding for Therapy and Counselling

Applicant's Name:	
Address:	
Telephone Number and Email Address:	
Name of Optometrist:	
Address of Optometry Clinic:	
Name of Counsellor:	
Office Address:	
Phone Number:	Fax Number:
Is this counsellor a Regulated Health Professional? No ☐ Don't Know ☐ Yes ☐	
If YES, name the College with which the counsellor is registered:	
Are the services of this counsellor covered by AHC or any other insurer? Don't Know ☐ No ☐ Yes ☐ If YES—*please provide details*:	
Have you already attended therapy or counselling for this matter? Yes ☐ Date when therapy or counselling started:_____(*attach copies of all invoices paid by you*) No ☐ Expected date therapy or counselling will start: _____	
Consent to Release Information *I agree to allow the Alberta College of Optometrists to contact the above named counsellor, as necessary to process this application for funding.* _____ Signature _____ Date	

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