ATTESTATION OF APPLICANT

Application for Funding for Therapy and Counselling

I_____ of the City of _____
(Patient Name)

in the Province of _____

Attest that_____ of the City of _____
(Name of counsellor)

1. Is not a person to whom I have any family, personal or business relationship and that the named counsellor is providing therapy and counselling to me for the matter that has come before the Alberta College of Optometrists.

AND,

2. The therapy and counselling services provided to me are not eligible for payment through Alberta Health Care or any other insurer and that the funds provided by the Alberta College of Optometrists are being utilized to pay for these therapies and counselling services.

AND IF APPLICABLE,

3. That the counsellor selected by me is not a member of a regulated health profession: the Alberta College of Optometrists cannot verify whether the named counsellor has ever been found guilty of professional misconduct of a sexual nature and/or sexual assault as defined by the Criminal Code of Canada.

_____ _____

Signature **Date**

#102 8407 – Argyll Road, Edmonton, Alberta T6C 4B2
Telephone: 1-800-668-2694 or 780-466-5999
Fax: 780-466-5969