



#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 1/2.]

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: _____

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:

Previous Discipline Activity

Have you ever been investigated, disciplined, charged or convicted of any activity of a sexual nature? Yes [] No []

If yes, please provide details:

Has any regulatory body or licensing authority in any Canadian province or territory, any State or any country ever denied, limited, restricted, suspended or cancelled your initial registration or your annual license renewal for the optometry profession or any other health care profession? Yes [] No []

If yes, please provide details:

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 \$3,000,000.00 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: _____