

**NON-PRACTISING STATUS UNDERTAKING FORM**  
**College of Optometrists of Ontario**  
**Acknowledgement and Undertaking of**

Updated: November 12, 2024

1. I, (Name of Optometrist) \_\_\_\_\_ am a member of the College of Optometrists of Ontario (the "College").
  
2. I hold:
  - a general certificate of registration # \_\_\_\_\_ with the College.
  - OR
  - an academic certificate of registration # \_\_\_\_\_ with the College.
  
3. I am requesting non-practising status with the College effective:
  - immediately. OR as of \_\_\_\_/\_\_\_\_/\_\_\_\_  
[day/month/year]
  
4. I am voluntarily providing this undertaking in exchange for the College granting me non- practising status.
  
5. While my registration status is non-practising, I undertake as follows:
  - a. I will not practise optometry in Ontario;
  - b. I will renew my certificate of registration annually;
  - c. I will pay all fees required of me under the *Optometry Act*, the Regulations and the College's By-laws;
  - d. I will comply with the mandatory continuing education requirements of the College's Quality Assurance program;
  - e. I will submit a completed member report annually in accordance with the College's By-laws;
  - f. If the College requests information of me, I will respond to the College in a timely manner and provide the requested information; and
  - g. I will notify the Registrar in writing of any change to information that I have previously provided to the College.

**LOCATION OF PATIENT RECORDS**

The College regularly receives calls from patients seeking assistance in locating their health record from members who are no longer in practice. When a member of the College ceases to practice, for whatever reason, the member's patients must continue to have access to the health information contained in their patient record.

If patient records have been relocated, patients must be notified of the location of their records and the procedure to follow to request access to or transfer of their records to another practitioner.

To assist us when contacted, please fill out the information below. My patient records have been transferred to -

Name of Optometrist: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: **ONTARIO** Postal Code: \_\_\_\_\_

How have patients been notified of the location of their health records and how to access them?

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6. I acknowledge and agree that my registration status and the details of this undertaking will be posted on the College's public Register.
7. Prior to my return to practise in Ontario, I undertake to:
  - a. Notify the Registrar in writing by submitting a completed Return to Practise form to the College;
  - b. Submit proof of my liability insurance to the College; and
  - c. Submit a completed Practice Location/Change of Information Form to the College.
8. I undertake that I will not resume practising optometry in Ontario until I have been notified in writing by the Registrar of my authorization to do so.
9. I acknowledge that the Registrar will authorize my return to practise in accordance with the following process:
  - a. If I have provided at least 750 hours of direct optometric care to patients in Canada in the three-year period before the date of my signed Return to Practise Form, I acknowledge that no further action will be required of me.
  - b. If I have not provided any hours of direct optometric care to patients in Canada in the three-year period before the date of my signed Return to Practise Form, I undertake to comply with and fulfill the following:
    - i. I will participate in a practice evaluation under the Quality Assurance program prior to my return to practise. I acknowledge that as part of the practice evaluation, I may be required to, among other things, answer oral or written questions that relate to practising optometry; answer oral or written questions that arise from a review of real or simulated patient charts; examine persons or clinical simulations exhibiting problems that relate to practising optometry; and demonstrate the application of optometric techniques;
    - ii. I will comply with any orders made by the Quality Assurance Committee arising out of the practice evaluation in accordance with the College's General Regulation, O. Reg. 119/94; and
    - iii. I will pay all costs related to the practice evaluation and any orders of the Quality Assurance Committee.
  - c. If I have provided some direct optometric care to patients but less than 750 hours of direct optometric care to patients in Canada in the three-year period before the date of my signed Return to Practise Form, I undertake to comply with and fulfill the following:
    - i. I will participate in a practice assessment under the Quality Assurance program within the first six months of my return to practise. I acknowledge that the practice assessment may include, but is not limited to, the inspection of my practice location; the inspection of approximately 25 patient charts; and the completion of a practice questionnaire. I acknowledge that the Quality Assurance Committee may make recommendations to me; require me to complete continuing education activities; or require me to undergo an evaluation of my clinical ability in accordance with the College's General Regulation, O. Reg. 119/94; and

ii. I will pay all costs related to the practice assessment.

10. If I am dissatisfied with any decision of the Registrar made under this Acknowledgement and Undertaking, I may request, in writing, that a panel of the Registration Committee review that decision.

11. I have read this Acknowledgement and Undertaking and understand my obligations under it. I have had an opportunity to seek independent legal advice and have either done so or decided not to seek such advice. I am signing this Acknowledgement and Undertaking voluntarily.

Signed at \_\_\_\_\_ [City], this \_\_ [Date] day of \_\_\_\_\_ [Month], \_\_\_\_\_ [Year]

\_\_\_\_\_

Signature of Member

\_\_\_\_\_

Signature of Witness

\_\_\_\_\_

Printed Name of Member

\_\_\_\_\_

Printed Name of Witness

Date Received at College: \_\_\_\_\_

<b>FOR COLLEGE USE ONLY:</b>
Info for the file – ICRC:
Info for the file - QA:
REGISTRATION STAFF: