COLLEGE OF Optometrists OF ONTARIO

Application for Funding for Therapy and Counselling

Applicant's Name	
Address	
Phone Number	
Name of Optometrist	

Date of Finding by the Discipline Committee:	
Date of Finding by a Court of Competent Jurisdiction:	
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 OHIP 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 College of Optometrists of Ontario to contact the above named counsellor, as necessary to process this application for funding.

_____ _____

Signature Date

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