

ATTESTATION OF APPLICANT
Application for Funding for Therapy and Counselling

I _____ of the City of _____
(Patient Name)

In the Regional Municipality / District of _____

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

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

AND

2. The therapy and counselling services provided to me are not eligible for payment through OHIP or any other insurer and that the funds provided by the College of Optometrists of Ontario 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 College of Optometrists of Ontario cannot verify whether the named counsellor has ever been found guilty of professional misconduct of sexual nature and or sexual assault as defined by the Criminal Code of Canada.

Signature

Date