

RETURN TO PRACTISE WITH PRACTICE LOCATIONS FORM

(updated Apr. 10, 2026)

Registrants returning to practise in Ontario, must complete and submit all information, as required on this form, directly to the College of Optometrists of Ontario.

Name: _____ Registration Number: _____

Date Returning to Practise: (DD/MM/YYYY) _____

Direct Patient Contact Hours

It is a condition of a certificate of registration that you must provide a minimum of 750 hours of direct optometric care to patients in Canada in every three-year period following the year in which you were first registered unless you signed an Acknowledgement and Undertaking. Each year, on the annual renewal report, you will have reported the number of patient contact hours you provided in Canada. At its meeting on August 11, 2022, the Registration Committee decided to allow non-practising registrants (who have been registered with the College for at least 3 years) who have provided at least 750 hours of direct optometric care to patients in the USA, to undergo a practice assessment at their [cost](#) before they can be transferred to the active class of registration, instead of being referred to a practice evaluation.

1. Date registered with the College of Optometrists of Ontario: (DD/MM/YYYY) _____
2. Have you provided direct optometric care to patients in the USA in the last three-year rolling period? NO YES [If 'No', please proceed to question 4.]
3. If your answer was 'YES' to question 2 above, please indicate the US jurisdiction you practised in, the number of direct optometric care hours you provided to patients in the USA, and the timeline it was provided in: In US jurisdiction _____, I provided direct patient optometric hours from (DD/MM/YYYY) _____ to (DD/MM/YYYY) _____.

You are then required to:

- a) provide a letter of standing at your cost from the jurisdiction in the US where you practised sent by email to the College at info@collegeoptom.on.ca where it indicates the number of direct optometric care hours you provided to patients and the timeline it was provided in,
- OR**
- b) have a non-relative practising optometrist you practised with in the US jurisdiction where you practised provide a letter on their company letterhead sent by email to the College at info@collegeoptom.on.ca indicating the number of direct optometric care hours you provided to patients and the timeline it was provided in (from (DD/MM/YYYY) to (DD/MM/YYYY)).

4. Please indicate the number of direct optometric care hours you provided to patients in Canada in the current calendar year: _____

If you have provided less 750 practice hours in Canada in the three years preceding your application to transfer to an active class, your application will be referred to the Quality Assurance Committee for their consideration of your practice hours. Depending on the number of practice hours you have completed in Canada, you may be required to complete a [practice assessment](#) or a [practice evaluation](#) at your cost in order to return to practise in Ontario. The administration fee (refer to the [Additional Requirements](#) section below) will be waived only for inactive registrants who are referred to undergo a practice assessment or practice evaluation at their cost.

Statement of Good Standing

Is there any current proceeding involving an allegation of professional misconduct, incompetence or incapacity or any like finding against you, in any other jurisdiction in which you are currently licensed?

NO YES

If YES, please provide details below:

By signing below, you are voluntarily confirming that the information you provided on this form is accurate:

Signature of Registrant

Date (DD/MM/YYYY)

Additional Requirements

Before returning to practise, you are required to provide the College with the following information:

1. **Complete the Practice Location section of this form** and return it to the College. (This form can also be found under Registration Management in the Resources section of our website.)
2. **Professional Liability Insurance** - You must provide proof that you are insured against professional liability, in accordance with the College by-laws (Section 21). (The by-laws can be found under Legislation, Regulations, & By-laws in the Resources section of our website.)
3. **Payment of an Administration Fee of \$118.65 (includes HST) along with the pro-rated membership fee** – refer to the Non-Practising Fee Administration Policy. (This Policy can be found under Policies & Guidelines – Administration in the Resources section of our website.)

FOR COLLEGE USE ONLY:

Sign off prior to status change required – ICRC:

Sign off prior to status change required – QA:

REGISTRATION STAFF:

Requirements Met:

Reactivation Date (DD/MM/YYYY): _____

PRACTICE LOCATION(S)

Name of Optometrist	
Registration #	

Primary Office

Please complete all questions.

Address <small>*include city, province, postal code, country</small>	
Starting Date (mm/dd/yy)	
Phone	
Fax	

Your days at this location:

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday
- Sunday

Employment relationship:

- Permanent
- Temporary
- Casual
- Self-employed

Employment status:

- Full-time
- Part-time
- Casual

Primary role:

- Owner/Operator
- Service provider (e.g., Associate)
- Administrator
- Consultant

- Instructor/Educator
- Manager
- Quality management specialist
- Salesperson
- Researcher

Client Age Range:

- Paediatrics (under 18 years)
- Adults

- Seniors (65 years or older)
- All ages
- Not applicable

Practice Settings:

- | | |
|--|---|
| <input type="checkbox"/> Solo Practice Office | <input type="checkbox"/> Assisted Living Residence/Supportive Housing |
| <input type="checkbox"/> Group Practice Office | <input type="checkbox"/> Group Health Centre |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Nurse Practitioner Led Clinic |
| <input type="checkbox"/> Rehabilitation Facility | <input type="checkbox"/> Post-secondary Educational Institution |
| <input type="checkbox"/> Residential/Long-term Care Facility | <input type="checkbox"/> Children Treatment Centre |
| <input type="checkbox"/> Client's Environment | <input type="checkbox"/> Mobile Imaging Centre |
| <input type="checkbox"/> Community Health Centre | <input type="checkbox"/> Other Place of Work |
| <input type="checkbox"/> Family Health Team | <input type="checkbox"/> Association/Government/Regulatory Org./No |
| <input type="checkbox"/> Independent Health Facility | |

Services provided at this location:

- | | |
|--|--|
| <input type="checkbox"/> ADP Authorizer | <input type="checkbox"/> Optical Coherence Tomography/Retinal Tomography |
| <input type="checkbox"/> Automated Visual Fields | <input type="checkbox"/> Orthokeratology |
| <input type="checkbox"/> Binocular Vision training | <input type="checkbox"/> Pre-School Children (2 – 5 years) |
| <input type="checkbox"/> Contact Lens Therapy | <input type="checkbox"/> Punctal Occlusion |
| <input type="checkbox"/> Corneal Topography | <input type="checkbox"/> Refractive Surgery Co-management |
| <input type="checkbox"/> Digital Retinal Imaging | <input type="checkbox"/> Spectacle Therapy |
| <input type="checkbox"/> Home Visits | <input type="checkbox"/> Sports Vision |
| <input type="checkbox"/> Infant Examinations (0 – 24 months) | <input type="checkbox"/> Visual Perception Testing and Therapy |
| <input type="checkbox"/> Institution Visits | <input type="checkbox"/> Wheelchair Access (to premises) |
| <input type="checkbox"/> Low Vision Therapy | <input type="checkbox"/> Wheelchair Accessible Eye Exams |
| <input type="checkbox"/> Occupational Safety Eyewear | |

List of names of regulated health professionals with whom you are associated, in partnership or otherwise:



Secondary Office

Please complete all questions.

Address *include city, province, postal code, country	
Starting Date (mm/dd/yy)	
Phone	
Fax	

Your days at this location:

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday
- Sunday

Employment relationship:

- Permanent
- Temporary
- Casual
- Self-employed

Employment status:

- Full-time
- Part-time
- Casual

Primary role:

- Owner/Operator
- Service provider (e.g., Associate)
- Administrator
- Consultant
- Instructor/Educator
- Manager
- Quality management specialist
- Salesperson
- Researcher

Client Age Range:

- Paediatrics (under 18 years)
- Adults
- Seniors (65 years or older)
- All ages
- Not applicable



Practice Settings:

- Solo Practice Office
- Group Practice Office
- Hospital
- Rehabilitation Facility
- Residential/Long-term Care Facility
- Client's Environment
- Community Health Centre
- Family Health Team
- Independent Health Facility

- Assisted Living Residence/Supportive Housing
- Group Health Centre
- Nurse Practitioner Led Clinic
- Post-secondary Educational Institution
- Children Treatment Centre
- Mobile Imaging Centre
- Other Place of Work
- Association/Government/Regulatory Org./No

Services provided at this location:

- ADP Authorizer
- Automated Visual Fields
- Binocular Vision training
- Contact Lens Therapy
- Corneal Topography
- Digital Retinal Imaging
- Home Visits
- Infant Examinations (0 – 24 months)
- Institution Visits
- Low Vision Therapy
- Occupational Safety Eyewear

- Optical Coherence Tomography/Retinal Tomography
- Orthokeratology
- Pre-School Children (2 – 5 years)
- Punctal Occlusion
- Refractive Surgery Co-management
- Spectacle Therapy
- Sports Vision
- Visual Perception Testing and Therapy
- Wheelchair Access (to premises)
- Wheelchair Accessible Eye Exams

List of names of regulated health professionals with whom you are associated, in partnership or otherwise:



Third Office

Please complete all questions.

Address *include city, province, postal code, country	
Starting Date (mm/dd/yy)	
Phone	
Fax	

Your days at this location:

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday
- Sunday

Employment relationship:

- Permanent
- Temporary
- Casual
- Self-employed

Employment status:

- Full-time
- Part-time
- Casual

Primary role:

- Owner/Operator
- Service provider (e.g., Associate)
- Administrator
- Consultant
- Instructor/Educator
- Manager
- Quality management specialist
- Salesperson
- Researcher

Client Age Range:

- Paediatrics (under 18 years)
- Adults
- Seniors (65 years or older)
- All ages
- Not applicable

Practice Settings:

- | | |
|--|---|
| <input type="checkbox"/> Solo Practice Office | <input type="checkbox"/> Assisted Living Residence/Supportive Housing |
| <input type="checkbox"/> Group Practice Office | <input type="checkbox"/> Group Health Centre |
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| <input type="checkbox"/> Community Health Centre | <input type="checkbox"/> Other Place of Work |
| <input type="checkbox"/> Family Health Team | <input type="checkbox"/> Association/Government/Regulatory Org./No |
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Services provided at this location:

- | | |
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| <input type="checkbox"/> ADP Authorizer | <input type="checkbox"/> Optical Coherence Tomography/Retinal Tomography |
| <input type="checkbox"/> Automated Visual Fields | <input type="checkbox"/> Orthokeratology |
| <input type="checkbox"/> Binocular Vision training | <input type="checkbox"/> Pre-School Children (2 – 5 years) |
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