

APPLICATION FOR LICENSE OR REGISTRATION

NOVA SCOTIA COLLEGE OF DISPENSING OPTICIANS
HALIFAX PROFESSIONAL CENTRE, SUITE 234
5991 SPRING GARDEN ROAD
HALIFAX, NS B3H 1Y6
Phone (902)425-7928 fax: (902)425-0360
E-mail: nscdo@ns.aliantzinc.ca

FOR OFFICE USE ONLY	
Approved By: _____	Date: _____
Expiry Date: _____	Fees Pd. _____
License Type _____	
Receipt NO. _____	License NO. _____
Professional Development Credits, If Applicable: _____	

IMPORTANT: READ BEFORE COMPLETING THIS FORM

1. Print or Type: Application not legible or those incomplete will be returned.
2. If insufficient space is provided, please attach additional information

The Undersigned applies for a License or Registration as (Please check)

- | | |
|--|--|
| <input type="checkbox"/> Dispensing Optician, New Candidate | <input type="checkbox"/> Contact Lens, New Candidate |
| <input type="checkbox"/> Dispensing Optician, Advanced Candidate
(has prior experience) | <input type="checkbox"/> Contact Lens, Advanced
Candidate |
| <input type="checkbox"/> Dispensing Optician, Student | <input type="checkbox"/> Contact Lens, Student |
| <input type="checkbox"/> Student License Renewal | <input type="checkbox"/> Student License Renewal |
| <input type="checkbox"/> | <input type="checkbox"/> Provisional License |
| <input type="checkbox"/> Non Practicing License | |

Surname of Applicant Given Names

Residence of Applicant _____ Suite/Apt. _____

City/Town _____ Province _____ Postal Code _____

Home Phone Number: _____ Cell: _____

E-mail address

Name of Business where you will be employed

Address of Business

City/town _____ Province _____ Postal Code _____

Business Phone Number: _____ Fax No: _____

Date of Birth: (DMY) _____

M.
replacement of receipt, Act or Regulations

Fee for
10.00