COLLEGE of OPTICIANS OF BRITISH COLUMBIA
a B.C. Health Regulator

NOTIFICATION OF OPTICAL STORE CLOSURE IN BRITISH COLUMBIA

Registrant's Name: _____ _____ _____
First Middle Last

Registration Number: _____

This notice serves to inform the College of Opticians of British Columbia of the closure of:

_____
Business Name

_____ _____
Unit # Building Name, Street Number and Name

_____ _____ _____ _____
City Prov. Postal Code Country

_____ _____ _____
Work Phone and ext. Work Fax Work E-mail

Date of Closure is effective starting on: _____
Month / Day / Year

Patient File Management:

Please indicate the storage name and location/address of the client files of the Closing Store. If the contact lens files are stored separately, please include the name and address of the Registered Contact Lens Fitter Dispensing Optician receiving the files.

_____

_____

_____

Actions Taken to Notify Patients of New File Location:

_____

_____

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