

B.C. COLLEGE OF OPTICS

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REGISTRATION

NAME _____

(Please *print* Entire Name as it should appear on your Graduation Certificate)

ADDRESS _____ CITY _____

PROVINCE _____ POSTAL CODE _____

TELEPHONE: Bus _____ Home _____

E-mail _____ Cell _____

Date of Birth _____

(day / month / year)

Social Insurance Number _____

WHOM DO WE CONTACT IN THE EVENT OF AN EMERGENCY?

Name _____ Relationship _____

Address _____ Telephone: _____

EDUCATION:

High School _____ Date of Graduation _____

Vocational College _____

University _____

Other _____

HOW DID YOU HEAR ABOUT US? _____

HAVE YOU WORKED IN THE OPTICAL FIELD? _____

If so, where? _____

Course Duration _____ (wks) Start Date/End Date _____

Non-refundable \$250.00 Registration Deposit paid? _____

FILE:

ACCEPTANCE:

Payments:

Date	Amount	Receipt No.

REMARKS: _____