

BC COLLEGE OF OPTICS

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R E G I S T R A T I O N

NAME _____

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

ADDRESS _____

CITY _____

POSTAL CODE _____

Date of Birth _____

Social Insurance Number _____

(day/month/year)

TELEPHONE: Bus _____

Home _____

Fax _____

E-mail/Cell _____

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? _____

	<u>Payments:</u>	<u>Date</u>	<u>Amount</u>	<u>Date</u>	<u>Amount</u>
FILE:					
ACCEPTANCE:					
REMARKS:					