

**OPHTHALMIC MEDICAL PERSONNEL PROGRAM CODE  
CERTIFICATE OF ACHIEVEMENT (PLEASE PRINT)**

It is important that you complete all of the information below.

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Province \_\_\_\_\_  
Postal Code \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_  
Work Phone (\_\_\_\_\_) \_\_\_\_\_  
Fax \_\_\_\_\_  
E-mail \_\_\_\_\_  
Employer's Name \_\_\_\_\_  
Your Position \_\_\_\_\_  
Date of Birth (mm/dd/yy) \_\_\_\_\_

Have you ever registered for a course or seminar at Centennial College? Yes No  
If yes, your student number please: \_\_\_\_\_

Please register me for:

- CEOA-906 Sec. 410 Fall Sec. 420 Winter Sec. 430 Summer
- CEOA-907 Sec. 410 Fall Sec. 420 Winter Sec. 430 Summer

Payment by: Money Order Credit Card  
Credit Card No \_\_\_\_\_

Expiry Date \_\_\_\_\_  
Cardholder's Name \_\_\_\_\_

Cardholder's Signature \_\_\_\_\_

**Please have your sponsor complete this section.**

Ophthalmologist Optometrist

I, \_\_\_\_\_ MD, recommend the applicant identified above for this program, and agree to offer didactic and practical assistance when required.

Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_

Postal Code \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Date \_\_\_\_\_

E-mail \_\_\_\_\_

Signature \_\_\_\_\_