MANITOBA ASSOCIATION OF Optometrists
Vision. Care.

BY-LAW 24 / 1

WHEREAS the Manitoba Association of Optometrists by virtue of Section 9 of The Optometry Act, Chapter O70 of the Revised Statutes of Manitoba, 1987, may make by-laws;

AND WHEREAS it is deemed advisable that by-laws be made by the said Association:

NOW THEREFORE, The Manitoba Association of Optometrists hereby makes and enacts the following by-law:

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1. DEFINITIONS

Where used in this By-Law, terms defined in Section 1 of The Optometry Act C.C.S.M. 070 (the "Act") have the same meaning as set out in the Act.

2. OBJECTS AND PURPOSES

The objects and purposes for the said Association are the objects and purposes set out in the Act, and in addition thereto, the following:

(1) The practical and scientific advancement of the members of the Association in the knowledge and practice of optometry, to the betterment of human vision;

(2) The collection and dissemination of information of value to the members of the Association and the direction of public opinion to the importance and value of optometric service;

(3) The promotion of good fellowship and communication among the members of the Association; and

(4) The upholding of the **Code of Ethics**, as set forth below.

It shall be the ideal, the resolve, and the duty of each registered member:

a) To accept as the registered member's primary concern and responsibility, the visual welfare of all patients;

b) To promote in every possible way high standards of vision care for all humankind;

c) To render optometric services with equal diligence to all patients, without discrimination;

d) To consult freely with colleagues and with members of other professions whenever such consultations are in a patient's best interest;

e) To observe the usual and customary procedures in consulting with or referring to a duly qualified medical practitioner a suspected medical problem where the consultation or referral is in a patient's best interest;

f) When a registered member and one or more other persons are involved in the treatment of one or more patients:

   i. to treat other health care providers with respect;

   ii. to recognize the skills, knowledge, competencies and roles of others involved in the patient's care, and communicate effectively and appropriately with the other health care providers;

   iii. to explain to the patient the registered member's role and responsibility;

g) To treat the patient with respect;

h) To act in the best interest of patients;

i) To avoid conflict of interest and disclose to patients if a conflict of interest has occurred that affects the patient's care;

j) To maintain appropriate professional boundaries with patients;

k) To prevent harm to patients and to disclose when there has been harm to the patient;

l) To disclose any moral conflicts that may influence the provision of care;

m) To seek continued growth of skill and knowledge, so that all patients may receive the full benefit of advances in the art and science of vision care;

n) To share professional knowledge and experience with colleagues so that all may benefit therefrom;

o) To hold in confidence any and all information concerning a patient and to use such information only for the patient's benefit except as required by law;

p) To report, on a form (Appendix D) provided by the Association, any adverse reactions suffered by any patient to any drug administered to that patient in the course of an examination; and

q) To maintain at all times the dignity, honour, and the integrity of the profession of optometry.

3. MEMBERSHIP

(1) Classification of Membership
There shall be four categories of members, namely registered members, optometric student (clerkship/ externship) members, student associate members, and honorary life members.

(2) Registered members
All members practising optometry under or by virtue of the Act shall be registered members. Registered members may be full-time or part-time (see Section 11(9) for definition of part-time membership).

(3) Optometric student (clerkship/externship) members
Optometric student (clerkship/externship) members shall be students registered as optometric students as defined in the Regulation to the Act. Optometric student (clerkship/externship) membership shall commence with the start date of the clerkship/externship and cease on the day following the end date of the clerkship/externship, according to clerkship/externship dates established by the optometric educational institution at which the student is registered. Optometric student members shall not have the right to practise optometry, vote or to hold office in the Association.

(4) Student associate members
Student associate members shall be students registered at an ACOE-accredited optometric institution who have applied and been accepted as student associate members.

a) Candidates for student associate membership shall apply in writing. There shall be no fee and no dues for student associate membership.

b) A student associate member shall not have the right to practise optometry, vote, or to hold office in the Association.

c) A student associate member shall not have the right to complete a clerkship(s)/externship(s) in Manitoba without registering as an optometric student (clerkship/externship) member as described in Section 3(3) and as defined in the Regulation to the Act.

d) Student associate membership shall continue from year to year so long as the student remains registered at an ACOE-accredited optometric institution and shall end on July 31 of the year in which the student's optometric education program is scheduled to conclude.

(5) Honorary life members
Honorary life members shall consist of those persons who have rendered valuable service to the science of or the profession of optometry, and who may be elected to such membership by the Association on recommendation of Council.

a) Honorary life members shall be entitled to a seat in the meeting of the Association and shall have the privilege of debating all questions before such meetings, but shall not have the right to practise optometry, hold office, or to vote, or to receive advice or mailings/emailings from the Association.

b) No application fee or annual dues shall be payable by an honorary life member.

c) No member may hold both honorary life membership and registered membership at the same time.

(6) A registered member of the Association who has not practised actively for three years may then be required to meet the Board of Examiners requirements for proof of competence.

(7) A registered member of the Association who has practised optometry in another jurisdiction, but not in Manitoba, for a period of five consecutive years, may be required to prove membership in good

standing of the relevant Association or College at all times in that jurisdiction, before the member's Manitoba status is renewed or changed.

(8) On the periodic renewal of their registration with the Association, each registered member must submit a criminal record check satisfactory to the Board, on the following schedule:

a) Registered members whose current registration with the Association commenced in a year ending with 2 (e.g. 2012) or 7 (e.g. 1967) must submit such criminal record check together with their renewal of registration for the 2017 year; and thereafter every five years;

b) Registered members whose current registration with the Association commenced in a year ending with 3 (e.g. 1993) or 8 (e.g. 1978) must submit such criminal record check together with their renewal of registration for the 2018 year; and thereafter every five years;

c) Registered members whose current registration with the Association commenced in a year ending with 4 (e.g. 1984) or 9 (e.g. 1989) must submit such criminal record check together with their renewal of registration for the 2019 year; and thereafter every five years;

d) Registered members whose current registration with the Association commenced in a year ending with 5 (e.g. 1975) or 0 (e.g. 1990) must submit such criminal record check together with their renewal of registration for the 2020 year; and thereafter every five years;

e) Registered members whose current registration with the Association commenced in a year ending with 6 (e.g. 1966) or 1 (e.g. 2001) must submit such criminal record check together with their renewal of registration for the 2021 year; and thereafter every five years.

Commencing in 2017, with every periodic renewal by a registered member for which a criminal record check is not required, each registered member shall confirm in writing whether or not they have been convicted of a criminal offense and, if the registered member has been convicted, provide information regarding that conviction to the Board of Examiners.

(9) Commencing in 2019, on the periodic renewal by a registered member of their registration with the Association, each registered member must submit proof of professional liability insurance satisfactory to the Board.

4. MEETINGS OF THE ASSOCIATION

(1) Annual Meetings

The Association shall hold at least one general membership meeting per year, at such time and place as the Council shall determine.

(2) Meetings of the Association may be held to transact any business at such time and place as may be decided upon by the Council or by the Association. Attendance at such meetings is open to all classes of membership as described in Section 3(1), employees, legal counsel and lay persons of the Manitoba Association of Optometrists. Other non-members will be permitted to attend a meeting by way of a motion from the floor and its subsequent affirmation.

(3) Notice of Meetings

Ten days' notice in writing of the time and place of all meetings shall be given to the members of the Association, and such notice may be given by email to the most recently reported email address of the member and by posting information about the meeting on the Association's website.

(4) Electronic attendance at Meetings

If determined by Council to be advisable, it may arrange for attendance or voting at a meeting by means of telephonic, electronic or other communication facilities if the means permit all persons participating in the meeting, including all persons who are entitled to vote, to communicate adequately with each other during the meeting.

A registered member who participates in, or attends or votes at, a meeting in a manner contemplated in this sub-section is deemed to be present in person at the meeting for all purposes, including determining quorum.

If notice of a meeting has been given or sent and the time, place or manner of holding the meeting is subsequently changed to hold the meeting as permitted by this sub-section, the Council must provide information about the change within a reasonable time by sending it to each person entitled to receive notice at the email address they provided to receive documents from the Association and by posting information about the meeting on the Association's website. A revised Notice of Meeting is not required if notice of a change is given in accordance with this sub-section.

For voting by means of telephonic, electronic or other communication facilities, the Council must take reasonable measures to ensure that the identity of each registered member who votes is verified and that each registered member who votes does so only in their own right.

(5) Quorum

The quorum for the transaction of business at any meeting of the Association shall be not fewer than one-quarter of the registered members present in person.

(6) Officers of Meetings

Meetings of the Association shall be called to order and shall be presided over by the president, or in the president's absence, by the vice-president, or in the absence of both of them by a member appointed by the registered members present to preside at such meeting.

(7) Parliamentary Authority

Robert's Rules of Order Newly Revised, 12th ed. (RONR) shall be the parliamentary authority for all meetings of Council and all meetings of the Association.

(8) Order of Business

The order of business at the annual meeting of the Association and, as far as possible, at all other meetings, shall be as follows:

a) reading and disposal of any unapproved minutes;

b) report of officers and committees;

c) unfinished business;

d) new business; and

e) election of Council.

(9) Voting

a) Subject to the provisions of sub-sections 4(4) and 4(9)(b), every registered member shall have the right to vote in person only, at any meeting of the Association and shall have one vote.

b) No registered member in arrears in respect of the payment of any dues or other moneys payable to the Association shall be entitled to vote on any matter brought before any meeting of the Association or to the election of any office.

5. ELECTION OF COUNCIL

(1) With the exception of the lay person, a registered member is eligible for election to Council:

a) who meets the qualifications set out in the Act;

b) who is not in default of payment of any dues or fees prescribed by the By-Laws;

c) whose professional conduct is not the subject of disciplinary action; and

d) who has not been found guilty of professional misconduct at any time in the previous three years.

(2) Council of the Association shall be elected by the registered members at each annual meeting by secret ballot.

(3) The nomination of candidates for election as members of Council shall:

a) be in writing;

b) be signed by the proposer and a seconder, both of whom shall be registered members; and

c) have the candidate's consent signed thereon.

(4) Where an elected member of Council:

a) is found to be an incapacitated member;

b) is found guilty of professional misconduct or incompetence;

c) fails to attend without cause three consecutive meetings of a committee or of the Council, or;

d) ceases to practise optometry;

the member is disqualified from sitting on the Council and the seat of the member on the Council shall be deemed to be vacant.

6. COUNCIL ORGANIZATION

(1) The Council of the Manitoba Association of Optometrists shall consist of the president, vice-president, secretary-treasurer, registrar, assistant registrar, three directors, and one lay person appointed by the Lieutenant-Governor in Council. Upon leaving office, the president shall automatically hold the position of past-president, until replaced by the next president whose term expires. The past-president shall be entitled to attend and speak at all meetings of Council but shall not be entitled to vote unless elected as a member of Council.

(2) Elections of members to Council shall be held at the annual meeting of the Association as follows:

a) three members elected to Council in 2016 and in each third year thereafter;

b) three members elected to Council in 2017 and in each third year thereafter;

c) two members elected to Council in 2018 and in each third year thereafter.

(3) At the meeting of Council immediately following the election of members to Council by the Association, the Council shall elect a president, vice-president, secretary-treasurer, registrar, assistant registrar, and any officers deemed necessary, from among its members.

(4) In the case when the president, vice-president, or secretary-treasurer ceases to be a member of Council before their respective terms are completed, the Council, at its next meeting, shall elect from among its members, a replacement for the unexpired term only.

(5) The term of office for all officers shall be one year from the date of election to that office, or until a successor takes over.

(6) Except where prohibited by law, the registrar may delegate to the assistant registrar any and all of the duties of the registrar.

(7) Council members may attend or vote at a Council meeting by means of telephonic, electronic or other communication facilities if the means permit all Council members participating in the meeting to communicate adequately with each other during the meeting. A Council member who participates in, or attends or votes, at a meeting in a manner contemplated by this sub-section is deemed to be present at the meeting for all purposes, including determining quorum.

(8) Notices of Council meetings, and agendas, minutes and other documents required to be circulated to members of Council may be delivered by email to the email address most recently provided by the

Council member to the Association, as well as by posting agendas, minutes and other documents on secured sections of the Association's website.

(9) For voting by means of telephonic, electronic or other communication facilities, the Council must take reasonable measures to ensure that the identify of each person who votes is verified and that each person who votes does so only in their own right.

(10) The executive director, MAO staff as necessary, the CAO councilor, and the new member representative may be entitled to attend Council meetings and may have the privilege of speaking to questions before such meetings, but shall not have the right to vote unless elected as a member of Council.

7. OFFICERS

(1) President

The president shall:

a) be the chief executive officer of the Association;

b) exercise general supervision and administration over all the affairs of the Association;

c) appoint the chairs of all standing and special committees;

d) when present, preside at all meetings of the Association;

e) see that all orders and resolutions of the Council are carried into effect;

f) be ex-officio member of all committees;

g) have the general supervision and direction of all the officers of the Association and shall see that their duties are properly performed;

h) submit a complete report of the operations of the Association for the year, and issue a statement of its affairs to the members at the annual meeting;

i) from time to time, report to the Association all matters that the interest of the Association require to be brought to its notice;

j) generally perform such duties as pertain to the office of the president; and

k) receive an honorarium for services as president of the Association, the amount to be decided by the Council.

(2) Vice-President

The vice-president shall:

a) be vested with all the powers of and be required to perform all the duties of the president in the president's absence;

b) perform such other duties as may be prescribed by the Council; and

c) receive an honorarium for services as vice-president of the Association, the amount to be decided by the Council.

(3) Secretary-Treasurer

The secretary-treasurer shall:

a) keep the minutes of all meetings of the Association and the Council;

b) notify all committees of their appointments;

c) give notice to the members of all meetings of the Association and the Council and conduct all its correspondence;

d) collect and keep all moneys of the Association and disburse the same for all running expense upon the approval of the president;

e) keep an account of financial transactions and report the same at each annual meeting of the Association and at any other time when required by the president;

f) at the expiration of the secretary-treasurer's term of office, deliver to the named successor all funds, papers and books relating thereto; and

g) receive an honorarium for services as secretary-treasurer of the Association, the amount to be decided by the Council.

(4) Registrar

The registrar shall:

a) keep the register of the Association;

b) enter therein the name of every person registered according to the Act, The Optometry Regulation and the By-Laws of the Association;

c) cause to be kept a record of:

i. registered members, including information on:

- full-time or part-time practice;
- optometric drug licences issued under the provisions of the Act;

ii. honorary members;

iii. continuing education requirements met by members

iv. professional corporations authorized by permit to practise optometry through a registered member as set out in the Act, The Optometry Regulation and the By-Laws of the Association;

d) enter the names of persons recorded in the register in the appropriate record;

e) serve as chair of the Board of Examiners; and

f) receive an honorarium for services as registrar of the Association, the amount to be decided by the Council.

(5) Assistant Registrar

The assistant registrar shall:

a) assist the registrar in all of their duties;

b) receive an honorarium for services as assistant registrar of the Association, the amount to be decided by the Council.

(6) Past-President

The past-president shall:

a) assist the president and council in carrying out their duties, with responsibilities as assigned by the president and council from time to time;

b) receive an honorarium for services as past-president of the Association, the amount to be decided by the Council.

8. RESOLUTION

A written resolution, signed by all members of the Council, shall be valid and binding and of the same effect as if such a resolution had been passed at a meeting of the Council. A decision made by a majority vote of Council by email between Council meetings shall have the same effect as a written resolution, and such an email decision shall be ratified by a vote of Council at its next regular meeting.

9. FEES

The fees for:

(1) examination**;**

(2) re-issuance of a registration certificate after revocation or lapse;

(3) optometric student registration;

(4) re-examination;

(5) appeal of refusal to register (refundable if successful);

(6) application for registration;

(7) issuance of registration certificate;

(8) issuance of drug licence;

(9) practice appraisal at the request of a registered member;

(10) practice appraisal for a registered member who has not provided 500 hours of direct patient care within the previous 2 years;

(11) registration of professional corporation;

(12) issuance of annual professional corporation permit;

(13) default in payment of membership dues (including late payment and returned cheques);

(14) fee for late renewal of annual professional corporation permit;

(15) NSF/returned cheque fee for all payments except dues; and

(16) continuing education/convention registration late fee;

shall be set by the Council and shall be published in a Schedule of Fees.

The per diem and honoraria payable to members for acting on Association business shall be determined by Council and published as a policy statement.

10. AUDIT

Once in every year, or more often if deemed advisable by Council, the accounts and books of the Association shall be audited by a competent auditor.

11. FINANCIAL

(1) The fiscal year end of the Association shall be December 31st.

(2) The Council shall submit a budget of the year's anticipated revenues and expenditures at the meeting of members following the fiscal year end.

(3) The Council shall prepare and distribute to the member an interim financial statement at the meeting of members following the fiscal year end. A final financial statement shall be distributed to those members who request it at such time as the statement is prepared.

(4) Dues for the Association shall be set at the meeting following the fiscal year-end by a majority vote of the registered members present.

(5) The method of payment shall be as follows:

a) Dues for the first half of the fiscal year (January-June) shall be invoiced and payable by December 31st, in advance of the commencement of the fiscal year, based on the previous year’s dues assessment.

b) The total assessed dues shall be invoiced subsequent to approval by the registered members, showing credit for the estimated first half-year pre-payment, and the balance owed.

c) Members shall remit payment of the balance in full to the MAO so that it is received by June 30th.

(6) Special assessments may be set by a majority vote of the registered members at any regular meeting of the Association.

(7) It is the duty of the secretary-treasurer to check the books within thirty days after all payment dates as noted in Subsection 11(5) above. If any member fails to pay the Association annual dues as described, including each incidence of late payment and/or returned cheques for any of the payment dates, the member will be assessed an automatic fine as described in the Schedule of Fees. The fine must be paid prior to the member being recognized as a member in good standing. Council may consider a registered member's appeal of fines and, at its discretion, reverse such assessment if it believes that special circumstances prevented the registered member's compliance with the By-Laws.

Council may cancel a registered member's registration for reason of default of payment of membership dues on thirty days' notice. Council may revoke such cancellation and re-instate the member upon such terms and conditions as it may deem advisable.

(8) A registered member who has been granted registration within one year after graduation and who has not registered as an optometrist or practised optometry in any other jurisdiction may be assessed dues at a reduced rate to be determined by Council.

(9) A registered member may apply annually for part-time membership by completing Appendix C, thereby committing to restrict their optometric practice to not more than 100 working days ("Working Days") in that year in any jurisdiction. On receipt of this commitment, Council shall reduce such registered member's annual dues to a sum that is equal to the amount of the annual per member CAO assessment plus 50% of the full annual dues for a registered member less the CAO assessment.

(i.e. .50 x [total dues - CAO assessment] + CAO assessment)

A Working Day is defined as any optometric activity in any given day. (e.g. 100 half days would constitute 100 Working Days.) Working Days providing volunteer optometric services on humanitarian eye care missions to developing countries with no remuneration are exempt from the maximum of 100 Working Days in that year in any jurisdiction.

(10) A registered member who actively practises for at least one day during the fiscal year of the Association will be responsible for paying the entire year's dues unless otherwise approved by Council in advance of the beginning of the Association's fiscal year. Upon commencement of the fiscal year, Council may, at its discretion, approve a reduction in dues payable in consideration of a registered member's special circumstances. In approving any reduction in dues after commencement of the fiscal year, Council may also assess an administration fee.

(11) Where an optometrist, presently not a registered member, is requested to temporarily take over the practice of a registered member who has recently deceased, or become incapacitated, or taken a leave of absence, a temporary registration may be granted by the Executive of the Council. The member shall pay, to the Association, dues pro-rated on a monthly basis. Such temporary registration shall not be authorized for a period exceeding three months without the approval of Council. The president shall advise the Registrar of such temporary registration.

12. EXAMINATION REQUIREMENT FOR REGISTRATION

(1) MAO Board of Examiners Directive

The Board shall issue a directive outlining the examination requirements and process for eligibility to practise optometry in Manitoba.

(2) Application Process and Fees

a) All optometrists interested in practicing in Manitoba must submit an application, including relevant documentation providing proof of qualification to practise, as stipulated in the Act and Regulation.

b) The Council shall set an application fee and examination fees, if applicable.

(3) Recommendation for Registration
The Board of Examiners shall meet annually, and more frequently at its discretion, to review applications for registration and decide on candidates' qualification to practise optometry in Manitoba.

13. APPEAL OF REFUSAL TO REGISTER

(1) An applicant who is denied registration may appeal in writing to the Council within 60 days after notice that the application is not accepted, stating the reasons why the applicant believes the refusal to register was unwarranted, and submitting the fee stipulated in Section 9.

(2) Upon receipt of an appeal, Council shall review the matter at its next regular meeting or, at its discretion, sooner if, in its view, circumstances warrant a speedier deliberation.

(3) In considering the appeal, Council may contemplate all matters raised by the applicant, which are pertinent to the applicant's qualification for registration.

(4) On conclusion of its review of an appeal, Council may:

a) confirm, alter or overturn the Board's decision; or

b) refer the matter back to the Board for further consideration in accordance with any direction that the Council may make.

14. PROFESSIONAL CORPORATIONS

Pursuant to the provisions of the Act, registered members may choose to carry on the practice of optometry through a professional corporation. The practice of optometry by a registered member through a professional corporation is subject to all provisions set out in the Act, the Optometry Regulation, and the By-Laws. If provisions of this By-Law conflict with provisions of the Act, the provisions of the Act shall prevail.

(1) Registration of professional corporation and issuance of initial annual permit
A registered member must submit an application to register a professional corporation to the registrar together with an application for an initial professional corporation permit. A professional corporation must file the following with the registrar when applying for registration of a professional corporation and issuance of the initial annual permit:

a) a copy of the articles of incorporation and any articles of amendment, continuance or amalgamation;

b) a current certificate of status issued under The Corporations Act;

c) a list of each registered member through whom the professional corporation will carry on the practice of optometry; and,

d) the application fee for registration of a professional corporation and the permit fee, as set out in the Schedule of Fees set by the Council.

(2) Professional corporation permit renewal and expiry
Every permit will expire on December 31 of the current year. For renewal of its professional corporation permit, a professional corporation must provide the following to the registrar on or before December 15 in the year in which its current permit expires:

a) a copy of its most recent annual report filed under The Corporations Act;

b) a list of each registered member through whom the corporation carries on the practice of optometry if there have been changes to the members since the date the corporation last applied for a permit or its renewal;

c) a list of the change, if any, to the shareholders, directors or officers since the date the corporation last applied for a permit or its renewal;

d) information about any conviction of the corporation for a criminal offence since the date the corporation last applied for a permit or its renewal;

e) the articles of amendment, continuation or amalgamation that were filed since the date the corporation last applied for a permit or its renewal; and

f) the permit fee as set out in the Schedule of Fees set by the Council.

A professional corporation that does not apply for renewal of its permit within the time period specified in this By-Law must pay, no later than January 15, the permit fee and the late fee specified in the Schedule of Fees in order to renew its permit. The permit may be renewed in accordance with the Act and this By-Law upon payment of those fees and is valid for the time period specified in the renewed permit. If not renewed by January 15, the permit will be cancelled, and the professional corporation must reapply for a new permit.

(3) Display of permit

Every registered member practicing through a professional corporation shall display the professional corporation's permit in a conspicuous place in the office or place where the registered member practices optometry.

(4) Name of professional corporation

A registered member must apply in writing to the registrar for approval of a proposed name for a professional corporation. On receipt of the application the registrar may approve a name that is not comprised of the first name(s) (or initials) and surname(s) of the voting shareholders but only if satisfied that the proposed name:

a) does not contain any reference that is offensive, not in good taste or contrary to the interests of the public or the honour and dignity of the profession or contravene the code of ethics;

b) does not refer to any person who is not a registered member;

c) does not imply expertise inconsistent with the qualifications of the registered members through whom the professional corporation will be practising;

d) does not claim or imply any superiority of one or any registered member or professional corporation over any other registered member or professional corporation;

e) is not false or misleading; and

f) does not so closely resemble the name of an existing approved professional corporation so as to be likely to create confusion.

The names of all professional corporations must include terms used to describe the practice of optometry, followed by the word "corporation". For greater certainty, the terms used to describe the practice of optometry shall include "optometric corporation" or "optometry corporation".

(5) Display of Names

Any professional corporation that carries on the practice of optometry under a name that is not comprised of the names of registered member(s) must display the full name of each professional corporation, partner corporation and registered member:

a) at each location where the practice of optometry is carried on; and

b) on the professional corporation's letterhead and, if it has one, on its website.

(6) Record of Professional Corporation

The record of professional corporations is to be maintained by the registrar. In addition to the information prescribed in the Act, the record of professional corporations must also contain the following information:

a) the time period during which the professional corporation's permit is valid; and

b) information about any suspension or cancellation of the professional corporation's permit or alternative action taken under section 17.8 of the Act, including any conditions placed on the permit.

If a professional corporation's permit expires, lapses, is cancelled, or is not renewed the registrar must remove the professional corporation's name from the record.

(7) Change of Professional Corporation Information
A professional corporation must inform the registrar of any change to the information in the permit application or permit renewal by submitting such changed information in writing to the registrar within 15 days after the change.

15. CONFLICT OF INTEREST

A conflict of interest is defined as any action or relationship which conflicts, or may reasonably be perceived to conflict, with a registered member's duty – as stated in the Code of Ethics – to assure that all professional decisions are made in the patient's best interests and without reference to any other criteria.

(1) To this end, a conflict of interest may occur when a registered member or their professional corporation is or comes to be in a situation which:

a) results in a direct or indirect gain, financial or otherwise, other than that earned from the performance of professional services in the registered member's practice, or

b) puts the registered member's professional integrity or rendering of services at risk of being controlled or influenced by other persons, business entities, corporations or factors other than the registered member's professional judgment of what is best for the patient, in accordance with generally accepted standards of practice, or

c) impedes the patient's ability to make an informed decision regarding consent to treatment or the purchase of services or materials related to the registered member's recommendations for care.

(2) Reporting Requirements

a) All registered members shall report their practice circumstances annually on their membership renewal form (Appendix A) and within seven days after the establishment of a new practice or a change in structure of an existing practice.

b) All registered members who have established a professional corporation shall report the name and other information required in accordance with this By-Law.

c) A registered member or professional corporation who has a financial interest in an ophthalmic dispensary which is physically or corporately separate from the registered member's or professional corporation's optometric practice shall, in addition to the above, disclose such interest by way of clearly visible signage on the dispensary's premises.

16. PROFESSIONAL MISCONDUCT

Professional misconduct includes:

(1) failing to abide by the terms, conditions or limitations of the optometric licence;

(2) failing to maintain the standard of practice of the profession;

(3) failing to maintain the records that are required to be kept in respect of a registered member's patients or practice;

(4) exceeding the lawful scope of practice;

(5) having a conflict of interest;

(6) using terms, titles or designations other than those that are authorized;

(7) permitting, counselling or assisting any person who is not licensed under the Act to engage in the practice of optometry except as provided for in the Act or the By-Laws;

(8) practicing or holding out that the member is engaged in the full-time practice of optometry in more than three offices or locations. A full-time member is defined as one who, on a regular basis, is engaged in the practice of optometry, for a period of time exceeding fifteen hours per week at a specific office or location;

(9) charging fees that are excessive in relation to the services performed;

(10) signing or issuing a certificate, report or similar document that contains a statement the member knows or ought to know is false, misleading or otherwise improper;

(11) signing or issuing a certificate, report or similar document that withholds statements or information the member knows or ought to know should be disclosed to the person to whom the document will be delivered or to whom the contents will be made known;

(12) knowingly submitting a false or misleading account of charges for services rendered to a patient;

(13) giving information concerning a patient's vision to any person other than the patient without the consent of the patient unless required to do so by law;

(14) falsifying a record in respect of observation or treatment of a patient;

(15) failing to carry out the terms of an agreement with a patient;

(16) refusing to allow an authorized representative of the Appraisal Committee to enter at an arranged reasonable time the office in which the member is engaged in the practice of optometry for the purpose of inspecting the registered member's professional records and equipment;

(17) being convicted of an offence that affects the suitability of a member to engage in the practice of optometry;

(18) engaging in the practice of optometry while the ability to perform any professional act is impaired by alcohol or drug;

(19) committing an act relevant to the practice of optometry that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional;

(20) giving misleading or false guarantees on ophthalmic materials and appliances, and/or giving any guarantees on diagnostic or treatment procedures; and

(21) failing to respond in writing to a written request for information from the Registrar, Complaints Committee, Appeals Committee or Discipline Committee within fourteen days after the date of the receipt of that request.

17. STANDARDS OF PRACTICE

(1) General

a) These standards of practice are a guide for the legislated scope of practice that registered optometrists are authorized to provide and the manner in which the optometrist provides those services. Standards of practice constantly evolve based on changes in optometric and medical

science, technology, certification of new optometric competencies and changes to the scope of practice of optometrists. Strict adherence to Standards of Practice does not substitute for good judgment exercised by individual optometrists in determining the actions to be taken – reflecting on each patient's circumstances. Optometrists adjust the care they provide based on each patient's needs and expectations, to optimize the individual patient's outcomes.

b) Each registered member shall ensure that:
   i. the optometric equipment available, and
   ii. the procedures used and the records established and maintained

   are adequate to enable correct diagnosis and, where appropriate, to provide for correct treatment of abnormalities of the visual system.

c) Each registered member shall ensure that the patient (and, as required, the patient's representative) has provided informed consent for all services and treatments provided and shall document any refusals in the clinical record;

d) Each registered member shall ensure that their premises are safe, sanitary, and appropriate for the practice of optometry.

e) When a registered member who practices in premises which are not owned or under the control of the registered member becomes aware that the premises are not safe, sanitary, and appropriate for the practice of optometry, the registered member must make all reasonable efforts to:
   i. Correct the inadequacies in the premises or optometric equipment, if possible, or
   ii. Bring the unsafe, unsanitary or inappropriate conditions to the attention of the employing member, professional corporation, group of members, or firm of optometrists that have control of the premises;

   and if the unsafe, unsanitary or inappropriate conditions are not or cannot be corrected in a reasonable period of time, the registered member must cease to practise in such premises.

f) Each registered member and professional corporation shall:
   i. maintain patient records of case history, all clinical procedures used, findings obtained, counsel given, treatment prescribed/given, and/or referrals provided in the assessment and management of the patient's vision performance.
   ii. advise the patient of fees and charges for services to be performed prior to the provision of services.
   iii. maintain the confidentiality and security of information contained in patient records.
   iv. have clearly visible practice signage indicating the registered member's name; and
   v. ensure that all notices and information pertaining to the provision of optometric services are done in the name of the registered member, professional corporation or optometric practice.

g) Upon transfer of ownership of a practice, new ownership of the practice shall be clearly indicated in all advertising for the practice.

   The name of a registered member or former registered member who has ceased practising at a practice shall not be included in any practice signage, advertising, or directory listing after one year from the date of leaving the practice, unless the term "succeeded by" or a variation thereof is used. The registered member's or former registered member's name may be used with such modifier for a period not exceeding five years from the date of leaving the practice.

h) Each registered member shall limit their practice to areas in which they have the requisite knowledge, skill and judgment. Where treatment of a patient is beyond their competency, the registered member must, unless declined by the patient, appropriately refer the patient, in a timely fashion, to another optometrist, physician or ophthalmologist for treatment.

i) An eye examination (Comprehensive or Partial) shall include the services shown in 17(4) or 17(5) as well as adequate documentation of all results, which should be completed during the examination or as soon as reasonably possible thereafter.

j) Where an abnormality of the patient's visual system is detected which requires referral, the registered member shall arrange for or offer to arrange for the appropriate referral. In circumstances where the patient refuses referral, the registered member should note such refusal in the clinical record. Specific provisions regarding referral and consultation with an ophthalmologist with respect to glaucoma and uveitis are set out in Section 17(14) of this By-Law.

(2) Minimum Optometric Equipment to Perform an Oculo-Visual Examination

The following list is the minimum optometric equipment required to perform an oculo-visual examination, all of which shall be kept in good repair and sound operating condition:

a) Lensometer

b) Visual acuity chart – to assess distance and near

c) Colour vision testing equipment

d) Phoropter, or trial lenses with frame, or similar devices to measure the subjective refractive error

e) Retinoscope

f) Binocular vision testing equipment

g) Keratometer/ophthalmometer

h) Ophthalmoscope

i) Tonometer

j) Biomicroscope

k) Transilluminator or similar light source for assessing pupillary function

Each registered member is responsible for appropriate decontamination, cleaning, disinfection and/or sterilization of multi-use equipment before use.

(3) Record Keeping

In order to provide documentation that quality care has been provided to the patient, the record must be:

a) Accurate – All data and test findings, and counselling are to be recorded.

b) Legible – Entries are to be clear and readable by the registered member and others.

c) Timely – Data and records of treatment should be entered as soon as reasonably possible after having been collected.

d) Comprehensive – All data and information collected from the patient should be included in the record.

e) Unaltered – If additions or corrections are made to the original record, the original entries must remain legible and intact. A single line is made through an error, by the person who made the original entry. The additions or corrections are initialed and dated. Computer-based clinical records should use a WORM (write once, read many function). The software used must be capable of identifying and recording when records are accessed, what edits are made, and by whom. The WORM window, after which no more changes are permissible, should be 60 days or less.

f) The clinical record should contain the following:

i. demographics of the patient (DOB, sex, guardian, address, medical number etc.)

ii. identification of the examining registered member or optometric student member

iii. date of each contact with the patient

iv. the case history

v. tests performed
vi. data collected from the tests performed
vii. diagnosis
viii. treatment or any prescription given, including therapeutic agents
ix. counselling given
x. fees and charges

Clinical records shall be retained for a period of at least Ten (10) years after the last entry or, in the case of minors, ten years after the time the patient would have reached the age of majority.

Registered members must comply with all requirements of the Personal Health Information Act with respect to patient records.

Registered members must have a plan in place to transfer patient records to another member/trustee in the event that the registered member ceases to practice unexpectedly (due to illness, absence, suspension or revocation, or death). Members will have until January 1, 2026 to complete their plan in accordance with this requirement.

(4) Comprehensive Oculo-Visual Examination & Patient Counselling

The following are minimum standards for a comprehensive oculo-visual examination and patient counselling. Additional tests and procedures may be required, depending on the patient's presenting complaint, the results of preliminary testing, the patient's age, physical and mental ability.

At the end of the Comprehensive Oculo-Visual Examination, the registered member should have evaluated the functional status of the eyes and visual system and assessed the ocular health and related systemic health conditions, and will counsel the patient on their visual, ocular and related systemic health care status, giving recommendations on treatment and future care.

The **Comprehensive Oculo-Visual Examination** should include, but is not limited to, the following:

a) Patient History
   i. identification of the examining registered member and, if applicable, the examining optometric student member
   ii. patient demographics (DOB, sex, guardian, address, medical number, etc.)
   iii. chief complaint and other vision or ocular problems reported by the patient
   iv. ocular history, including measurement of patient's present optical correction
   v. general health history
   vi. family's ocular and medical history
   vii. use of prescribed and non-prescribed medications
   viii. medication allergies
   ix. work and hobby visual requirements

b) Preliminary Testing
   i. distance and near visual acuity (type of correction recorded)
   ii. observation of facial and external ocular areas
   iii. pupillary responses

c) Refraction
   i. measurement of the distant refractive status (with visual acuity)
   ii. measurement of the near refractive status (with visual acuity)

d) Ocular Health Assessment
   i. examination of the external eye and adnexa

ii. measurement of the intraocular pressure (19 years of age and over, or when otherwise indicated)
iii. internal ocular examination
iv. visual fields assessment (when indicated by signs and symptoms, or history)

e) Oculomotor and binocular vision assessment, if relevant to the specific clinical situation
i. presenting binocular vision status
ii. accommodative status

f) Assessment and Diagnosis
i. optometric analysis of the data collected to produce a diagnosis and a treatment plan, including further testing or referral when indicated
ii. communication of diagnosis and treatment recommendations

g) Patient Counselling
i. discussion with the patient and/or guardian regarding the patient's oculo-visual status regarding the presenting visual symptoms, complaints, and any other oculo-visual abnormality detected
ii. explanation on how the present systemic condition has or can affect the oculo-visual system
iii. discussion and explanation of the treatment options
iv. recommendation and referral to the appropriate health care provider, when indicated
v. recommendation for re-examination
vi. acknowledge the patient's (and, as required, the patient's representative's) right and responsibility to participate, to their level of ability and preference, as partner in decisions affecting their health
vii. respect the patient's (and, as required, the patient's representative's) knowledge, values, preferences and cultural background in the planning and delivery of care
viii. provide accurate and unbiased information in a timely manner sufficient to enable the patient (and, as required, the patient's representative) to effectively participate in care and make an informed decision about the best course of action for their care
ix. inform the patient about self-management of their condition

(5) Partial Oculo-Visual Examination & Patient Counselling

A partial Oculo-Visual Examination is performed for a specific clinical situation, usually when the registered member deems that a Comprehensive Oculo-Visual Examination is not required, based on their sound professional judgment.

The **Partial Oculo-Visual Examination** should include, but is not limited to, the following:

a) Patient History relevant to the specific clinical situation
i. identification of the examining registered member and, if applicable, the examining optometric student member
ii. patient demographics (DOB, sex, guardian, address, medical number, etc.)
iii. chief complaint and other vision or ocular problems reported by the patient
iv. ocular history, including measurement of patient's present optical correction
v. general health history
vi. family's ocular and medical history
vii. use of prescribed and non-prescribed medications
viii. medication allergies
ix. work and hobby visual requirements

b) Preliminary Testing

i. visual acuities (unaided and/or aided)
ii. other procedures which are relevant to the specific situation

c) Refraction, if relevant to the specific clinical situation

d) Ocular health assessment, if relevant to the specific clinical situation

e) Oculomotor and binocular vision assessment, if relevant to the specific clinical situation

f) Assessment and Diagnosis
i. optometric analysis of the data collected to produce a diagnosis and a treatment plan, including further testing or referral when indicated
ii. communication of diagnosis and treatment recommendations

g) Patient Counselling
i. discussion with the patient and/or guardian regarding the patient's oculo-visual status regarding the presenting visual symptoms, complaints, and any other oculo-visual abnormality detected
ii. explanation on how the present systemic condition has or can affect the oculo-visual system
iii. discussion and explanation of the treatment options
iv. recommendation and referral to the appropriate health care provider, when indicated
v. recommendation for re-examination
vi. acknowledge the patient's (and, as required, the patient's representative's) right and responsibility to participate, to their level of ability and preference, as partner in decisions affecting their health
vii. respect the patient's (and, as required, the patient's representative's) knowledge, values, preferences and cultural background in the planning and delivery of care
viii. provide accurate and unbiased information in a timely manner sufficient to enable the patient (and, as required, the patient's representative) to effectively participate in care and make an informed decision about the best course of action for their care
ix. inform the patient about self-management of their condition

(6) Diabetes Mellitus Clinical Guidelines

An Oculo-Visual Examination of a patient with Diabetes Mellitus shall include, but is not limited to, the following:

a) Patient History of Diabetes Mellitus
i. Family history of Diabetes Mellitus
ii. Type and duration of the patient's Diabetes Mellitus
iii. A review of medical management of the patient's Diabetes Mellitus

b) Ocular Examination
i. Comprehensive oculo-visual examination as per 17(4)
ii. Screening for diabetic retinopathy
Suggested Screening Methods:
- Dilated fundus examination via direct ophthalmoscopy or indirect slit lamp fundoscopy.
- Digital fundus photography (fundus photography does not replace the need for a thorough dilated fundus exam).

iii. Additional tests as clinically indicated

c) Management
i. Patient education
ii. Patients who present with diabetes mellitus (DM) must be screened for eye disease:

- For patients who are 15 years of age or older with Type 1, screening should be undertaken annually, 5 years after the onset. Screening is generally not indicated before puberty.
- For patients with Type 2, screening should be undertaken at the time of the initial diagnosis, and then at least annually based on stage of retinopathy, if any (see table below).
- Patients with poorly controlled DM or proteinuria should be examined at least annually.
- Patients with DM who become pregnant should have an eye examination during the first trimester, with subsequent monitoring throughout the pregnancy and post-partum.

iii. Manage non-retinal ocular complications in accordance with current optometric standards of care

iv. Manage diabetic retinopathy as follows:

Suggested Frequency of Eye Examination for Patients with Diabetes
(subject to resource availability, specifically medical/surgical retinal specialists)

Stage of Retinopathy	Diagnostic Characteristics	Macular Status	Frequency of Examination	Referral Timing
No apparent retinopathy	No abnormalities	No DME	Every 12 months	No referral necessary
Mild NPDR	MA	No DME	Every 12 months	No referral necessary
		DME	Every 4 to 6 months	No referral necessary
		CSME	Every month	Within 1 month
Moderate NPDR	MA IRH HE CWS	No DME	Every 6 to 12 months	No referral necessary
		DME	Every 3 to 6 months	No referral necessary; monitor carefully for CSME
		CSME	Every month	Within 1 month
Severe or very severe NPDR	Any one of the '4:2:1 Rule': 4: IRH (particularly dark-blot IRH) in 4 retinal quadrants 2: venous beading in 2+ quadrants 1: IRMA in 1+ quadrant Very severe NPDR: 2 or more features of severe NPDR	No DME	Every 2 to 6 months	If very severe, within 1 month: consider PRP Review at least every 6 months once stabilized
		DME	Every 2 to 4 months	If very severe, within 1 month: consider PRP Review at least every 6 months once stabilized
		CSME	Every month	Within 1-2 weeks: consider PRP Review at least every 6 months once stabilized
PDR	NVD NVE VH PRH	No DME	Every 2 to 4 months	Within 2 weeks: consider PRP Review at least every 6 months once stabilized
		DME	Every 2 to 3 months	Within 2 weeks: consider PRP Review at least every 6 months once stabilized
		CSME	Every month	Within 1 week: consider PRP Review at least every 6 months once stabilized
High-risk PDR	Severe NVD: larger than 1/4 to 1/3 disc area Severe NVE: larger than 1/2 disc area VH or PRH with fibrovascular proliferation or tractional RD	No DME	Every 2 to 3 months	Within 1 week: PRP Review at least every 6 months once stabilized
		DME	Every 1 to 3 months	Within 1 week: PRP Review at least every 6 months once stabilized

		CSME	Every month	Within 1 week: PRP Review at least every 6 months once stabilized

Definitions:
Diabetic macular edema (DME) is defined as: Retinal thickening or HE detected through stereoscopic examination of the posterior pole, but not within the criteria set for clinically significant macular edema (CSME).
Clinically significant macular edema (CSME) is defined as: Retinal thickening at or within 500 microns of the centre of the macula; and/or HE at or within 500 microns of the centre of the macula with adjacent retinal thickening; and/or retinal thickening of one disc-diameter in size, at least part of which is within one disc-diameter of the centre of the macula.
Refer CSME to ophthalmology for immediate treatment (within 1-2 weeks if accompanied by more advanced retinopathy).
Review at least every 3 to 6 months once stabilized.

A patient with sudden severe vision loss or signs/symptoms of retinal detachment should be immediately referred to an ophthalmologist able to treat proliferative disease/CSME.

Other abbreviations:
CWS – cotton wool spots
DR – diabetic retinopathy
HE – hard exudates
IRH – intraretinal hemorrhages
IRMA – intraretinal microvascular anomalies
MA – microaneurysms
NPDR – non-proliferative diabetic retinopathy
NVD – neovascularization of the disc
NVE – neovascularization elsewhere
PDR – proliferative diabetic retinopathy
PRH – preretinal hemorrhage
PRP – panretinal photocoagulation
RD – retinal detachment
VEGF – vascular endothelial growth factor
VH – vitreous hemorrhage

The above table was informed by:
American Academy of Ophthalmology Retina/Vitreous Panel. 2016. Diabetic Retinopathy Preferred Practice Pattern. Available at www.aao.org/ppp

American Optometric Association. American Optometric Association Evidence-Based Clinical Practice Guideline: Eye Care of the Patient with Diabetes Mellitus. St. Louis, MO: American Optometric Association; 2014. Available at www.aoa.org/Documents/EBO/EyeCareOfThePatientWithDiabetesMellitus%20CPG3.pdf

Canadian Ophthalmological Society Diabetic Retinopathy Clinical Practice Guideline Expert Committee. COS evidence-based clinical practice guidelines for management of diabetic retinopathy. Can J Ophthalmol. 2012; 47:1-30.

International Council of Ophthalmology: ICO Guidelines for Diabetic Eye Care. San Francisco, CA: International Council of Ophthalmology; 2017. Available at www.icoph.org/downloads/ICOGuidelinesforDiabeticEyeCare.pdf

(References: 2017 CAO Clinical Practice Guideline: Optometric Care of the Patient with Diabetes 2. Canadian Journal of Optometry Vol. 79 Supplement 2, 2017. www.researchgate.net/publication/333579370_2017_CAO_Clinical_Practice_Guideline_Optometric_Care_of_the_Patient_with_Diabetes_2. Accessed April 12, 2023.

Evidence-Based Clinical Practice Guideline: Diabetes. Alberta College of Optometrists, 2021.)

(7) Myopia Management Clinical Guideline

a) Children with the following risk factors should be considered for a myopia management program:
   i. Myopia
   ii. 6 years or younger with refractive error of +1.00 D or less
   iii. Parent(s) with myopia
   iv. Refractive error progressing more than -0.75 D/year
   v. East Asian ethnicity

   Optometrists who identify risk factors for progressive myopia should discuss options with caregivers and consider intervention with myopia control. If the member does not offer treatment, they should refer to an optometrist who does myopia management.

b) The following should be performed when initiating myopia management:
   i. Patient history
      - Family history of myopia (parents and siblings)
      - Time spent reading or using digital devices
      - Date of myopia onset (if known)
      - Any previous treatments for myopia
   ii. Ocular examination
      - Distance and near acuity
      - Internal and external ocular health assessment
      - Subjective refraction or retinoscopy
      - Accommodative and BV testing
      - Axial length measurement if available

c) Treatment methods
   i. Myopia control spectacle lenses
   ii. Myopia control contact lenses
   iii. Center distance design bifocal contact lenses
   iv. Orthokeratology
   v. Topical Atropine drops
   vi. Controlling environmental factors
   vii. Combination of the above

d) Management
   Management and frequency of follow-ups will depend on the method chosen.
   i. At each follow-up the following should be performed:
      - Case history
      - Issues related to treatment
      - Corrected far visual acuity
      - Subjective refraction or retinoscopy
   ii. 6 month followup is recommended
   iii. At 1 year followup:
      - Comprehensive examination

(References: World Council of Optometry Myopia Management Resource Committee. Myopia Moment Clinical Interventions. World Council of Optometry, 2021. https://myopia.worldcouncilofoptometry.info/myopia-management-clinical-interventions-english/. Accessed April 12, 2023.

World Council of Optometry Myopia Management Resource Committee. Myopia Moment How to Choose an Intervention. World Council of Optometry, 2021. https://myopia.worldcouncilofoptometry.info/myopia-management-how-to-choose-an-intervention-english/. Accessed April 12, 2023

World Council of Optometry Myopia Management Resource Committee. Myopia Moment What to Measure. World Council of Optometry, 2021. https://myopia.worldcouncilofoptometry.info/myopia-measurement-what-to-measure-english/. Accessed April 12, 2023.

World Council of Optometry Myopia Management Resource Committee. Myopia Moment Patient Follow-up. World Council of Optometry, 2021. https://myopia.worldcouncilofoptometry.info/myopia-measurement-patient-follow-up-english/. Accessed April 12, 2023.

Zadnik K, Sinnott L, Cotter S. Prediction of Juvenile-Onset Myopia. JAMA Ophthalmol, 2015. https://jamanetwork.com/journals/jamaophthalmology/fullarticle/2206339. Accessed April 12, 2023.)

(8) Glaucoma Clinical Guideline

Patients who present with glaucoma risk factors should be screened for eye disease.

a) Strong risk factors for developing glaucoma include:
   i. Elevated intraocular pressure (>21 mm Hg in at least one eye)
   ii. Increasing age (particularly people 50 years of age and older)
   iii. Family history of glaucoma (in first-degree relatives)
   iv. African or Hispanic ethnicity
   v. Thin central corneal thickness
   vi. Enlargement or asymmetric cupping of the optic nerve head
   vii. Myopia (higher than -3.00 diopters, with increasing risk with each additional diopter)
   viii. Ocular history (e.g. trauma or injury, prior ocular surgery, prolonged use of corticosteroids in any form or route, particularly topical drops)
   ix. History:
      - Medical history
      - Ocular history
      - Current medications and allergies
      - Family history (medical and ocular)

b) Ocular Examination

   If glaucoma is suspected (based on risk factors or clinical findings during a routine eye examination), a comprehensive glaucoma assessment should be initiated. In addition to the Comprehensive Oculo-Visual Examination (Section 17(4)) the comprehensive glaucoma assessment should include i. – x. below, and it is recommended to include xi. – xiii.:
   i. Family and personal (ocular and general) health history
   ii. Assessment of other possible risk factors
   iii. Relevant information and data from previous assessments
   iv. Corrected visual acuities
   v. Pupil responses
   vi. Central corneal thickness
   vii. Applanation intra-ocular pressure including time of day (Goldmann or Perkins is considered the current standard of care and is required for all glaucoma suspects and glaucoma patients)
   viii. Assessment of the anterior chamber angle and anterior uvea (gonioscopy is considered the current standard of care)
   ix. Assessment of the retina and optic nerve (dilated fundus examination is considered the current standard of care)
   x. Computerized threshold visual fields
   xi. Stereoscopic ONH photography (preferred) or standard fundus photography
   xii. Scanning laser imaging of the optic nerve and macula including analysis of the Retinal Nerve Fiber Layer (OCT or similar instrument)
   xiii. Any other supplemental testing as per the professional discretion and judgment of the optometrist appropriate to that specific patient

c) Management

   Qualified Optometrists are able to manage glaucoma as per Section 17(14).

   Depending on the type, severity and progression of glaucoma, the following procedures should be performed and documented on glaucoma patients on a regular basis as part of their regular monitoring:

i. If using IOP lowering medications, confirmation and documentation of time of last dose, compliance and any adverse reactions
ii. Corrected visual acuities
iii. Pupil responses
iv. Applanation intra-ocular pressure (Goldmann or Perkins) including time of day
v. Assessment of the anterior chamber angle and anterior uvea (gonioscopy is considered the current standard of care)
vi. Dilated fundus examination
vii. Computerized threshold visual fields
viii. Stereoscopic ONH photography (preferred) or standard fundus photography
ix. Scanning laser imaging of the optic nerve and macula including analysis of the Retinal Nerve Fiber Layer
x. Any other supplemental testing as per the professional discretion and judgment of the optometrist appropriate to that specific patient

d) Appropriate Reassessment Schedule
   i. Glaucoma suspect
      - Glaucoma suspects are people who have one or more glaucoma risk factors in one or both eyes or clinical features that suggest they are likely to develop glaucoma
      - Assessment interval: every 6 months to 2 years
      - Clinical features: one or more of the following:
        - Suspicious 24-2 (or similar) visual field defect
        - Intraocular pressure greater than 21 mm Hg
        - Suspicious structure, disc, or cup-to-disc asymmetry of greater than 0.2 in optic nerve heads of equal size
   ii. Early or mild-stage glaucoma:
      - Assessment interval: at least every 12 months
      - Clinical features: early glaucomatous disc features (mild RNFL and/or GCC loss on OCT) and/or mild visual field defect not within 10 degrees of fixation (e.g. mean deviation better than -6 dB on Humphrey Visual Field Analyzer 24-2)
   iii. Moderate-stage glaucoma:
      - Assessment interval: at least every 6 months
      - Clinical features: moderate glaucomatous disc features (moderate RNFL and/or GCC loss on OCT) and/or moderate visual field defect not within 10 degrees of fixation (e.g. mean deviation from -6 to -12 dB on Humphrey Visual Field Analyzer 24-2)
   iv. Advanced-stage glaucoma
      - Assessment interval: at least every 4 months
      - Clinical features: advanced glaucomatous disc features (vertical cup-to-disc ratio >0.9) and/or advanced visual field defect within 10 degrees of fixation (e.g. mean deviation worse than -12 dB on Humphrey Visual Field Analyzer 24-2)

e) Referral
   Referrals to ophthalmology should be arranged as per Section 17(14)b) Treatment of Open Angle Glaucoma.

(References: Ontario Provincial Vision Task Force. Quality Standards: Glaucoma Care for Adults. Health Quality Ontario, 2019. https://www.hqontario.ca/Portals/0/documents/evidence/quality-standards/qs-glaucoma-qs-en.pdf. Accessed April 12, 2023.

Evidence-Based Clinical Practice Guideline: Glaucoma. Alberta College of Optometrists, 2021.)

(9) Pharmacologic Dilation Clinical Guideline

Pharmacologic dilation of the pupil is generally required for a thorough evaluation of the ocular media and posterior segment. Dilation can also facilitate examination of the anterior segment structures when certain conditions are present or suspected. The results of the initial dilated examination usually indicate the appropriate timing for subsequent pupillary dilation.

a) The following lists some of the situations/patient symptoms in which dilation is strongly recommended when appropriate with the informed consent of the patient. These situations/patient symptoms include but are not limited to:
   i. symptoms of flashes of light (photopsia), onset of or a change in number or size of floaters
   ii. unexplained or sudden vision change, loss, or distortion (metamorphopsia)
   iii. the use of medication that may affect ocular tissues (including but not limited to hydroxychloroquine, phenothiazine, long-term steroids)
   iv. the presence of systemic disease that may affect ocular tissues (including but not limited to diabetes, hypertension)
   v. a history of significant ocular trauma, or ocular surgery that increases risk to the posterior segment
   vi. a history of moderate to high axial myopia
   vii. when a better appreciation of the fundus is required (including but not limited to choroidal nevus, optic nerve anomaly)
   viii. when the ocular fundus is not clearly visible through an undilated pupil (including but not limited to cataract)
   ix. when there is a known or suspected disease of:
      - the vitreous (including but not limited to vitreous hemorrhage)
      - the optic nerve (including but not limited to glaucoma)
      - the macula (including but not limited to age-related macular degeneration)
      - the peripheral retina (including but not limited to lattice degeneration)
      - the choroid (including but not limited to melanoma)

b) Optometrists choose the dilating agent after considering the extent of pupillary dilation desired, the patient's health history and clinical ocular characteristics, as well as the implications of expected side effects on the patient's activities and safety.

c) Cycloplegic refraction is indicated on the assessment of children and young adults and is recommended in, but not limited to, the following circumstances:
   i. suspected clinically significant latent hyperopia
   ii. unexplained reduced visual acuity
   iii. suspected amblyopia
   iv. risk of developing amblyopia secondary to accommodative esotropia or asymmetric refractive error
   v. on initial assessment for a myopia management program
   vi. for pre-refractive surgery consult

   Cycloplegic refraction is repeated when clinically indicated.

d) When using cycloplegic agents, optometrists must:
   i. be familiar with the properties of any cycloplegic agents they use;
   ii. counsel patients appropriately regarding the expected effects and anticipated duration of action of the agent; and

iii. consider the presence of any significant contraindications to the use of a cycloplegic agent prior to instillation (e.g. narrow anterior chamber angle, past history of angle closure attacks or other adverse reactions or hypersensitivities to similar agents, etc.).

(Reference: Optometric Practice Reference: Standard of Practice. College of Optometrists of Ontario, 2020, s 6.2 and 7.6.)

(10) Contact Lens Examination

The following are minimum procedures for contact lens fitting, which must be performed and recorded in the patient's record:

a) Perform a comprehensive oculo-visual examination prior to the contact lens examination, if no current clinical data from a comprehensive examination is available.

b) Obtain further history specific to the fit of the contact lenses. This should include reasons for contact lens wear (e.g. cosmesis, sports, occupation), ocular and medical history (any reasons which restrict or contraindicate contact lens wear), and past contact lens history.

c) Conduct a biomicroscopic evaluation of the eyelids, lashes, palpebral and bulbar conjunctiva, tear layer, and cornea. Measure ocular and eyelid parameters which influence the selection of lens type.

d) Measure the corneal curvature and adjust the refractive error to the corneal plane.

e) Evaluate the fit of a trial lens and make alterations if required to arrive at a successful fit of the selected contact lens.

f) Prescribe the contact lens required after over-refraction and alteration of the fit (e.g. type of lens, material selection, physical parameters of the lens).

g) Educate the patient on insertion and removal of the lenses, proper cleaning and disinfection, and other general instructions regarding the wear of contact lenses.

h) Schedule the appropriate **contact lens progress evaluations**, as follows:

i. A contact lens progress evaluation includes a case history specific to the contact lens wear, visual acuities with the contact lenses, an over-refraction and a biomicroscopic evaluation of the contact lens fit and the physiological response of the eye to contact lens wear and, if required, measurement of the corneal curvature. The registered member must analyze the data collected and counsel the patient with recommendations for ongoing treatment.

ii. The number of contact lens progress evaluations depends on the physiological response of the eye to contact lens wear and the fit of the contact lens.

iii. Proper methods must be used for cleaning and sterilization of contact lenses that will be used from patient to patient (see methods outlined in the Infection Control Guidelines in subsection 17(11) below).

iv. If a registered member becomes aware of other ocular conditions during contact lens fitting, they must diagnose and offer to treat the condition or refer appropriately using sound clinical judgment.

(11) Infection Control

Registered members must utilize appropriate precautions to prevent exposure to and/or transmission of infectious diseases. The following policy relates to guidelines proposed by the Centers for Disease Control (CDC), the American Optometric Association (AOA), the American Academy of Optometry, and Health Canada. The Manitoba Association of Optometrists will endeavor to update these Guidelines as new information becomes available but reminds registered members that it is their responsibility to ensure they are aware of and follow proper practises.

a) Universal Precautions

The CDC recommends that blood and body fluid precautions be consistently used for all patients. The CDC recognizes blood and certain body fluids of all patients to be potentially infectious for HIV,

the hepatitis B virus, and other bloodborne pathogens. Universal precautions, therefore, apply to blood, specific body fluids, and all body fluids containing visible blood.

Universal precautions do not apply to tears unless they contain visible blood. While HIV has been isolated in trace quantities in tears, the CDC recognizes tears as only a theoretical (not clinical) mode of transmission, in that the likelihood of transmission is either extremely remote or non-existent.

As medical history and examination cannot reliably identify all patients with infectious diseases, universal precautions should be consistently used for all patients.

b) Infection Control in Optometric Practice
The Manitoba Association of Optometrists (MAO) recognizes the need for the establishment of infection control guidelines to be practised when examining all patients.

i. Handwashing – It is the responsibility of registered members and their staff to practise effective handwashing before and after examinations, and after procedures where there is a possibility of exposure to blood or body fluids. Hands should be washed with soap and thoroughly dried with a fresh cloth towel or disposable paper towels. As an alternative when hands are not visibly soiled, the use of an approved hand sanitizer is appropriate.

ii. Disposable Gloves – Registered members should adhere to appropriate barrier precautions to prevent skin and mucous membrane exposure when in contact with blood or other potentially infectious materials. Disposable gloves should be readily available for use by registered members and their staff. Wearing gloves is not a substitute for handwashing. The following are Health Canada recommendations for disposable glove use:

- Use sterile gloves for procedures involving contact with normally sterile areas of the body.
- Use examination gloves for procedures involving contact with mucous membranes and for diagnostic procedures that do not require the use of sterile gloves.
- Both sterile and examination gloves are single use only.
- Hands should always be washed after gloves are removed.
- General purpose utility gloves (neoprene, rubber, butyl) are to be used for housekeeping chores involving potential blood content, and for instrument cleaning and decontamination. Utility gloves may be decontaminated and reused as long as there is no sign of deterioration.

iii. Protective Gowns, Masks, and Eyewear – These items are unnecessary for routine optometric practice. They should, however, be used whenever the possibility of transmission of airborne pathogens, splashes of blood or other body fluids may occur.

iv. Instruments and Equipment – Health Canada adopts Spaulding's classification system for medical instruments. The method for proper cleaning, disinfection, or sterilization of reusable instruments is based on the potential risk of infection involved in the use of that instrument. Medical instruments and equipment are divided into three classes:

- Critical – Critical items are instruments or objects that routinely penetrate the skin or mucus membranes into normally sterile areas of the body, or come into contact with recirculating body fluids. If not purchased sterile, these objects must be physically cleaned, rinsed, and sterilized before use. Sterilization can be achieved by heat (autoclave) or by chemical sterilization. Instruments must be packaged to maintain sterility.
- Semicritical – These items come in contact with intact mucous membranes, but do not ordinarily penetrate normally sterile areas of the body. These objects must be physically cleaned, rinsed and undergo high level disinfection before use.
- Noncritical – These are items that do not ordinarily touch the patient or touch only intact skin. Depending on their use, only physical cleaning and/or low level disinfection are necessary before reuse.

v. Cleaning, Disinfection and Sterilization of Instruments and Equipment – The majority of ophthalmic equipment is categorized as semicritical and noncritical. Most ophthalmic instruments can therefore be sterilized by heat (autoclave) or disinfected by immersion for 10 minutes in one of the following fresh solutions, recommended by the CDC:

- 3% hydrogen peroxide
- 1/10 dilution (0.5% solution) of common household bleach (sodium hypochlorite)
- 70% ethanol or isopropyl alcohol

The device should be thoroughly rinsed in tap water and dried before reuse.

Alcohol should not be used to soak tonometer, biprisms or gonioscopic contact lenses, since it may damage these lens surfaces over time. Hydrogen peroxide would be the solution of choice.

vi. Contact Lenses – Trial contact lenses must be properly disinfected after each patient use using one of the following CDC recommended procedures:

- Hard (PMMA) lenses – Can be disinfected with a 3% hydrogen peroxide solution approved for soft contact lens use. Most hard lenses may also be disinfected using the standard heat treatment regimen for soft lenses (78-80 degrees centigrade for 10 minutes).
- Rigid Gas Permeable (RGP) lenses – Can be disinfected using a 3% hydrogen peroxide system approved for soft contact lenses. RGP lenses should not be heat disinfected as they may warp.
- Soft Contact Lenses – Can be disinfected with an approved hydrogen peroxide system.

vii. Handling and Disposal of Sharp Instruments – Precaution and care should be used to prevent injury in the use and disposal of such instruments. After use, disposable syringes, needles, scalpel blades, and other sharps should be placed in a puncture-resistant container for disposal. Local regulations should be consulted for instructions regarding the proper disposal of sharps in that jurisdiction. Nondisposable sharps should be placed in puncture resistant containers for transport, cleaning and sterilization.

c) Evolving Infection Control Procedures

Health Canada recommends that employers of health care workers should ensure that employees are educated about the transmission and prevention of infectious diseases, and the need for routine use of universal precautions for all patients. Equipment and supplies necessary to follow universal precaution guidelines must be provided. Registered members must monitor the infection control practices in their offices to ensure the adherence to recommended guidelines.

During times when there may be a public health concern, federal or provincial public health authorities (i.e. the Public Health Agency of Canada) or organizations such as the World Health Organization or Centres for Disease Control and Prevention may make recommendations for changes to established infection control procedures. The Council of the Manitoba Association of Optometrists, considering such recommendations, may make changes to the provisions in this section. Changes shall be effective immediately upon notice to registered members without the need for consultation with or vote by the registered members of the Association. Notice shall be provided at the most recent email address provided by the registered member to the Association.

(12) Collaborative Care

In providing care to patients, registered members must work collaboratively with other health care professionals and others who provide care to the patient, as circumstances require, to provide integrated care and avoid duplication of services;

When a registered member and one or more other persons are involved in the treatment of one or more patients, a registered member must:

a) Treat other health care providers with respect

b) Recognize the skills, knowledge, competencies and roles of others involved in the patient's care and communicate effectively and appropriately with the other health care providers; and

c) Explain to the patient the registered member's role and responsibility.

(13) Patient Referral

Referrals, when required, must be made in a timely manner, based on sound clinical judgment, to other appropriate health care providers. The patient's care can be totally or partially transferred to the other health care provider.

a) Indications for referring a patient include:
   i. Treatment of a diagnosed ocular condition when the treatment is beyond the clinical competency of the referring registered member.
   ii. To obtain a second opinion, as in a consultation.
   iii. Assessment of a systemic condition, which is related to a diagnosed ocular condition.

b) The referral shall be made with the patient's consent. Information transferred to the other health care provider shall include:
   i. a reason for referring the patient
   ii. pertinent case history
   iii. available appropriate ocular data
   iv. diagnoses or tentative diagnoses, if any

Where a registered member has provided services as a result of a consultation due to a referral from another practitioner, the consulting registered member should encourage the patient to return to the referring practitioner.

(14) Treatment with Drugs designated in Schedule A to the Optometry Regulation

a) EMERGENCY Treatment of Acute Angle Closure Glaucoma and Other Acute Glaucomas:
   i. A registered member who holds a therapeutic drug license may initiate treatment of acute angle closure glaucoma, and other acute glaucomas in cases where the applanation intraocular pressure is significantly elevated at presentation.
   ii. A registered member who holds a therapeutic drug license must, however, immediately refer the patient to an ophthalmologist.

b) Treatment of Open Angle Glaucoma
   i. A registered member who holds a therapeutic drug license may treat open angle glaucoma with up to two classes of glaucoma medications.
   ii. A referral for consultative and collaborative treatment with an ophthalmologist must be made in a timely fashion if during the course of treatment any of the following occur:
      - IOP measurements do not meet target IOP levels (despite use of up to two classes of glaucoma medications);
      - signs of advanced or progressive thinning of the neuro-retinal rim;
      - signs of advanced or progressive glaucomatous visual field loss;
      - consideration of adding a third class of glaucoma medication; or
      - other signs that glaucomatous damage is progressing despite treatment.
   iii. All initial optometric requests sent to the consulting ophthalmologist for collaborative glaucoma treatment should include the patient's visual acuities, intraocular pressures by applanation tonometry, assessment of both anterior chamber angles and optic nerves, as well as copies of visual fields and a summary of glaucoma treatment to date.
   iv. The consulting ophthalmologist shall decide the frequency of their reassessment of the glaucoma patient as well as the collaborative relationship between the registered member

and the consultant ophthalmologist based on each individual case. It is recommended that the frequency of reassessment and the nature of the collaborative relationship be reflected in writing between the registered member and ophthalmologist with respect to each patient.

v. Subsequent reports between the registered member and ophthalmologist shall include all information required as agreed upon in the collaborative model developed by the registered member and ophthalmologist.

vi. A registered member who holds a therapeutic drug license may alter therapy as a result of ongoing monitoring but must notify the consulting ophthalmologist of any such changes in therapy.

c) Uveitis

A registered member who holds a therapeutic drug license may treat anterior uveitis with topical steroids in consultation and collaboration with an ophthalmologist, as follows:

i. A registered member who prescribes a topical steroid in the treatment of anterior uveitis must refer the patient to an ophthalmologist in a timely fashion if there is no improvement in the condition in the first 72 hours after initiation of treatment.

ii. A registered member who prescribes a topical steroid in the treatment of anterior uveitis must refer the patient to an ophthalmologist for a systemic workup in the case of a diagnosis of anterior uveitis that is either:

- recurrent
- bilateral
- granulomatous
- and for which no previous systemic workup has been performed.

iii. A registered member may not treat posterior or intermediate uveitis or any uveitis in a child.

iv. A registered member must consult with an ophthalmologist if the uveitis recurs within three months of cessation of therapy.

v. A registered member may reinitiate topical steroid in subsequent presentations of anterior uveitis in those patients with a previous systemic workup.

vi. A registered member treating anterior uveitis with topical steroids must monitor intraocular pressure.

(15) Prescription Release

a) A spectacle prescription or contact lens specification is derived from the evaluation of diagnostic tests and measurements conducted during an eye examination. As such, they form part of the patient's clinical record.

b) While the registered member compiling the records maintains the custody and control of clinical records (unless transferred to the custody or control of another authorized trustee), patients have a right to access the information contained in the record.

c) The registered member must give the written spectacle prescription to the patient upon request when, in the opinion of the registered member, the appropriate treatment may include the use of corrective lenses. The registered member shall respond to requests for contact lens specifications, once developed, as information from the clinical record, in accordance with the provisions of Section 17(16) – Spectacle and Contact Lens Prescription Specifications.

d) All prescriptions and contact lens specifications should be dated. The registered member should determine the recommended examination interval in respect of a given patient and communicate this recommendation to the patient. This recommendation may be noted on the prescription, e.g. "Re-examination is recommended after MONTH-YEAR," or "Filling this prescription after MONTH-YEAR is not recommended without re-examination."

e) While patients requesting a copy of a prescription after the recommended re-examination date are entitled to the information contained therein, this information should be accompanied by a disclaimer that it is for information only – and is not a prescription.

(16) Spectacle and Contact Lens Prescription Specifications

a) Spectacle Prescriptions

i. The minimum requirements of a spectacle prescription include the sphere, cylinder, axis, reading add (if required), prism (if required), examination date and expiry date and signature of the prescribing registered member.

ii. Dispensing procedures and specifications such as PD measurement, lens alignment, height measurement, frame selection, lens selection, lens coatings and fitting of the frames are not considered part of an eye examination, and thus not part of the spectacle prescription. These services, if provided, may be subject to a fee to the patient.

iii. If additional tests were not performed to determine whether the patient is a candidate for contact lenses, it is considered appropriate and reasonable to indicate “spectacle prescription only” or “not a prescription for contact lenses” on the prescription.

iv. A copy of the prescription shall be given to the patient upon request. Repeated requests of the same prescription or requests made after the eye examination date may have an administrative fee charged to the patient.

v. If a spectacle prescription has expired, patients are still entitled to receive a copy of the expired prescription for informational purposes.

vi. Suppliers of eyeglasses shall only provide eyeglasses when presented with a current and valid eyeglass prescription.

vii. On release of information from patient files, it is reasonable for the registered member to request a waiver signed by the patient/guardian acknowledging that prior dispensing information may not be appropriate or sufficient for the production of new spectacles.

viii. Release of information already on file is subject to the requirements of PHIA and a reasonable administrative fee may be charged.

ix. Notes or advice that do not relate to the patient's health or vision needs are extraneous to these principles and are therefore not appropriate for inclusion on the prescription.

b) Contact Lens Prescriptions

i. A contact lens prescription is not one of the expected results of a routine eye health and vision examination. A contact lens prescription can only be released after the fitting process (i.e. progress check) has been completed.

ii. A contact lens prescription should include the minimum specifications required to order contact lenses, and would normally include lens name, base curve, diameter, power, expiry date and signature of prescribing registered member. Additional contact lens specifications may be required for specialized fittings and/or materials (as determined by the registered member’s clinical judgment).

iii. After completing the fitting and all required progress evaluations, a copy of the contact lens specifications shall be provided to the patient upon request. Repeated requests or requests made after the eye examination date may have an administrative fee charged to the patient.

iv. If a contact lens prescription has expired, patients are still entitled to receive a copy of the expired prescription for informational purposes. The expired prescription may not be used to manufacture or dispense new contact lenses.

v. Suppliers of contact lenses shall only provide contact lenses when presented with a current and valid contact lens prescription.

vi. Verification and dispensing of contact lenses should be performed by a regulated professional (i.e. optometrist, ophthalmologist or contact lens certified optician).

vii. On release of information from patient files, it is reasonable for the registered member to request a waiver signed by the patient/guardian acknowledging that prior dispensing information may not be appropriate or sufficient for the dispensing of new contact lenses.

viii. Release of information already on file is subject to the requirements of PHIA and a reasonable administrative fee may be charged.

(17) Patient Records on Termination of Practice

On termination of practice, patients whose files are active should be advised who they can contact for access to the clinical record relating to their care. This notification shall be provided by mail, email or by advertisement in a local newspaper. In addition to providing notification to patients, the registered member and/or professional corporation must provide information to the Manitoba Association of Optometrists as to where patient files can be accessed, and, unless transferred to the custody of another registered member or professional corporation, the registered member and/or professional corporation must provide updated information at any time the information with respect to access to these patient records changes. If the registered member ceases to be a member of the Manitoba Association of Optometrists for any reason, the patient files must be transferred to the custody of another registered member or professional corporation currently practising in the Province of Manitoba.

Transfer of records must be covered by a written agreement, including free access to the records by the transferring registered member or professional corporation and an understanding that the receiving registered member will have direct access only to the records of those patients who seek professional advice from the receiving registered member and therefore have implied consent to a review of the records. The registered member holding the files must also agree to abstract relevant information on request of the patient concerned. Finally, the agreement must stipulate when the records may be ultimately destroyed.

18. LABORATORY TESTING CLINICAL PRACTICE GUIDELINE

The objective of this guideline is to provide guidance to registered members on ordering and analyzing laboratory tests. It is based on the best available and most current optometric and medical clinical evidence and research. It is not intended to replace professional discretion and judgment; nor is it intended to be used as an all-encompassing clinical manual. Registered members must base their diagnostic, management, treatment and referral regimens on the specific needs of the patient.

(1) Goals

It is the goal of every registered member to collaborate and communicate with patients, legal guardians and other health care practitioners in order to:

a) increase access to competent vision care services,

b) maximize a patient's visual status and quality of life,

c) improve patient compliance and outcomes,

d) reduce the possibility of duplication of tests and services, and,

e) provide vision care services in the most efficient and effective manner.

(2) General Guideline

Registered members who hold a Therapeutic Drug Licence may order and receive reports of screening and diagnostic tests specified in Schedule B to the Optometry Regulation.

(3) Specific Guidelines

a) Registered members must only order lab tests if indicated to assist in the diagnosis and/or management of an ocular condition for a patient.

i. Registered members must only order those lab tests that they are personally competent to order, interpret and use to achieve appropriate patient outcomes.

ii. The registered member should contact an appropriate health care provider and request that the necessary lab tests be ordered if:

- the registered member determines that they are not competent to order and interpret the necessary lab tests;
- it is inappropriate for the registered member to order the necessary tests; or,
- the registered member is unable to order the necessary tests for any other reason.

b) To avoid duplication, registered members must review all alternative sources of current lab test results available to them about a patient prior to ordering a test for the patient (e.g. electronic health record, communication with another health practitioner, etc.).

c) Each registered member must have a system in place to ensure the appropriate follow-up of critical results for ordered lab tests.

i. "Critical test results" are test results that are significantly out of the normal range and which need to be communicated to the registered member urgently.

ii. Each registered member who orders lab tests is responsible to ensure that specific arrangements are in place for the registered member to receive communication respecting critical test results.

iii. The registered member who receives communication respecting critical test results is responsible to promptly assess whether the results require urgent follow up and take the appropriate action on behalf of the patient.

d) When ordering lab testing, registered members must:

i. provide the diagnostic facility with a telephone number at which the registered member or the registered member's designate may be reached and which may be used by the diagnostic facility to communicate critical test results to the registered member or the registered member's designate.

ii. provide pertinent information about the patient for use by the diagnostic facility to help determine whether a test result is critical.

iii. If a registered member is unable to be personally available to receive the critical test results, the registered member must make arrangements with another registered member to be available to receive the critical test results and to provide the appropriate follow-up communication and care to the patient promptly.

e) A registered member who orders a diagnostic test or makes a referral to another health care professional must have a system in place to review the test results and the results of referrals to other health care professionals and have reasonable arrangements in place to follow-up with the patient when necessary.

f) Registered members who make decisions as a result of interpreting lab test results must:

i. document the decision and the rationale for the decision in the patient's record of care;

ii. explain the interpretation of the data, the decision and the rationale for the decision to the patient or legal guardian, if the patient or legal guardian is able to understand the information and it is appropriate to do so; and,

iii. include a reference to the lab data, and the decision in any communications with other registered members of the patient's health care team.

g) Registered members must respect the patient's right to confidentiality by ensuring that they collect, use, and disclose lab test results only when it is pertinent to the care they are providing and that the collection, use and disclosure is only done in accordance with the Personal Health

Information Act, other applicable privacy legislation and other legislation and standards governing optometry practice.

h) A registered member must not provide an interpretation of the results of lab tests ordered by other health care providers to the patient unless it is pertinent to the care being provided by the registered member. In all other instances the patient must be referred to the health care provider who requested the test or created the data in the EHR for interpretation of the data.

i) A registered member who orders a diagnostic test and directs a copy of the results to another registered member remains responsible for any follow-up care required, unless the registered member to whom a copy of the results is directed has agreed to accept responsibility for the patient's follow-up care.

(4) Clinical Practice Reference Guidelines

a) Microbiology Lab Tests – culture and sensitivity studies of organisms obtained from the ocular surface or adnexa; or viral studies of organisms obtained from the ocular surface or adnexa may be ordered for those patients when indicated in their optometric care and when microbiology lab studies are an appropriate diagnostic tool for their clinical diagnostic problem. *(Reference: Optometric Clinical Practice Guideline: Care of the Patient with Conjunctivitis. American Optometric Association 2007 - www.aoa.org/documents/optometrists/CPG-11.pdf)*

b) Registered members are to follow clinically accepted protocols for the collection of conjunctival swabs *(Reference: Optometric Clinical Practice Guideline: Care of the Patient with Conjunctivitis. American Optometric Association 2007 - www.aoa.org/documents/optometrists/CPG-11.pdf)* and to utilize the collection kits supplied by the provincial laboratory approved to provide this service to Manitoba Optometrists.

c) Orbital X-Rays – Orbital X-Ray imaging may be ordered for patients when indicated in their optometric care and when orbital X-Ray testing is the appropriate diagnostic imaging modality of choice for their clinical diagnostic problem. *(Reference: Canadian Association of Radiologists Diagnostic Imaging Referral Guidelines, 2012, Section B: Head and Neck - www.car.ca/uploads/standards%20guidelines/car-referralguidelines-b-en_20120918.pdf)*

19. ADVERTISING OF OPTOMETRIC SERVICES AND PRODUCTS

(1) General

a) Nothing in this section shall limit the right of the Manitoba Association of Optometrists to publicize the profession.

b) Advertising that serves the purpose of making the public aware of objective facts relevant to the practice and/or services provided by one or any registered member or professional corporation is permissible. Advertising of such a nature that it may have the effect of promoting one or any registered member, or professional corporation, in relation to another is not permissible.

c) Any registered member who engages in, or is employed by, or who allows their name to be associated with any individual, registered member, professional corporation, or other firm or corporation that engages in the advertisement of optometric products or services contrary to the provisions of the By-Laws shall be subject to disciplinary action.

(2) Ethical Requirements

Any advertisement, notice, announcement or sign shall:

a) be true and accurate;

b) be of a professional and dignified nature, in good taste, and otherwise such as to not bring the optometric profession into disrepute;

c) not be misleading or deceptive or likely to mislead or deceive; and

d) not claim or imply any superiority of one or any registered member or professional corporation, over any other registered member or professional corporation.

(3) Part-Time Office

Where an optometric office is not staffed by a registered member on a regular basis for a period exceeding an average of 15 hours per week, that office shall be considered a part-time office. Any advertising of any kind referring to this office shall indicate the hours when optometric services are available.

(4) Association Trademark or Logo

The Association may establish a trademark or logo for use by the Association or on behalf of its membership for such purposes as deemed appropriate by Council. To protect the integrity of the logo and its use restricted to the Association as an entity, Council may, at its discretion, register such trademark or logo.

20. CONTINUING COMPETENCE

(1) By December 1 of the last year of each Reporting Period, all registered members are required to provide a report, in the manner specified by the Board of Examiners, summarizing continuing education credit hours completed in the Reporting Period.

(2) All registered members are required to provide 500 hours of direct optometric care to patients within each Reporting Period. For registered members who initially registered as an optometrist within a Reporting Period (i.e. new grads), the 500 hour requirement is pro-rated to the month of initial registration as an optometrist. As part of the continuing education proof of participation, each registered member shall attest to providing the minimum number of practice hours.

(3) In the event that a registered member is unable to practise direct optometric care for the required number of hours of optometric practice due to health or other reasons, Council shall at its discretion suspend the registered member's registration or refer the registered member to the Appraisal Committee for evaluation of the registered member's practice.

(4) All registered members are required to furnish proof of participation in no fewer than forty credit hours of continuing education in each Reporting Period, fifteen hours of which must reasonably be related to the treatment and management of ocular disease.

(5) All registered members are required to furnish proof of participation in no fewer than one credit hour of continuing education related to cultural competency in each Reporting Period.

(6) All registered members must provide proof of satisfactory completion of Cardiopulmonary resuscitation (CPR) certification (minimum CPR-C or equivalent) in each Reporting Period. Such certification must have been completed during the Reporting Period for which proof is provided, regardless of the time period for which the certification is valid. CPR must be completed in person (not online) in order to meet the requirement.

(7) Failing to complete the required continuing education credit hours as described in Section 20 by December 31 of the last year of the Reporting Period, without a justifiable excuse, shall constitute grounds for a financial penalty of $250 on January 1 of the following year, and an additional penalty of $250 on January 31 if the credit hours have still not been completed and submitted. The Board of Examiners may waive one or both penalty fees on written application by a registered member if the registered member was unable to complete the credit hours due to extenuating circumstances.

Failing to maintain the required continuing education credit hours as described in Section 20 within two months after the end of the Reporting Period, without a justifiable excuse, shall constitute grounds for suspension of registration. The Board of Examiners may extend the two-month grace period on

application in writing by a registered member if the registered member was unable to complete the credit hours due to extenuating circumstances.

(8) An exemption of twenty hours of continuing education credits will be granted for successful completion of the Optometry Examining Board of Canada Written Examination and Objective Structured Clinical Examination (OEBC Exam) in that Reporting Period.

(9) To be recognized for CE credit, presentations or courses must be related to the maintenance of optometric standards of competence, be accessible and open to all practicing optometrists, and be provided or coordinated by Recognized Bodies and qualified instructors.

(10) **"Recognized Bodies"** in this section, means educational institutions, optometric colleges and associations, academies and other professional or corporate bodies recognized by the Board of Examiners.

(11) **"Reporting Period"** in this section, means a two-year period, commencing on January 1 of each odd-numbered year, and ending on December 31 of the immediately following even-numbered year.

(12) **Eligible Credit Hours**

a) Participation in educational courses, lectures or seminars provided or coordinated by recognized bodies, provided by a Manitoba Ophthalmologist, or which have received COPE approval through the Association of Regulatory Boards of Optometry. Participation must be in-person or synchronous (live) online.

APPROVED CREDIT: hour-for-hour or as recommended by the course coordinator.

b) Publication of articles in refereed optometric or ophthalmological journals.

APPROVED CREDIT: 5 hours per distinct article.

c) Publication of case reports in refereed optometric or ophthalmological journals.

APPROVED CREDIT: 2 hour per distinct case report.

d) Formal presentation of optometric continuing education programs coordinated by recognized bodies.

APPROVED CREDIT: 2 hours per 1-hour distinct presentation.

e) Self-study continuing education approved by recognized bodies, including asynchronous online courses, journal articles, or other self-study material approved by the Board of Examiners. All self-study continuing education must include a refereed test.

APPROVED CREDIT: hour-for-hour or as recommended by the course coordinator.

f) Participation in cultural competency educational courses, lectures or seminars provided or coordinated by MAO, MAHRC, WRHA, or other Canadian recognized bodies providing healthcare cultural competency.

APPROVED CREDIT: hour-for-hour or as recommended by the course coordinator.

g) Serving as a preceptor for an optometric student clerkship/externship.

APPROVED CREDIT: 1 hour credit to the supervising optometrist for each day supervising a student clerkship/externship to a maximum of 2 hours per year (4 hours per Reporting Period). Date of supervision, student name and optometry school must be identified.

h) Developing or correcting optometric examination questions and/or serving as an assessor.

APPROVED CREDIT: Credit as recommended by the examining body for OEBC or NBEO examinations to a maximum of 5 hours per Reporting Period.

i) Fellowship in the Canadian College of Specialties in Optometry (CCSO), American Academy of Optometry (FAAO) or Diplomate in the American Academy of Optometry (DAAO). Credits used to

complete CCSO Fellowship, FAAO or DAAO may not be submitted individually for credit in other categories in sub-section (12).

APPROVED CREDIT: 30 hours credit for obtaining either CCSO Fellowship, FAAO or DAAO in reporting period completed.

j) Cardiopulmonary resuscitation (CPR) certification.

APPROVED CREDIT: hour-for-hour to a maximum of 3 credit hours per reporting period. CPR certification must be completed in person (not online) in order to be eligible for credit.

k) Practice management.

APPROVED CREDIT: A maximum of 10 credit hours total from any eligible credit hour category may be related to practice management per reporting period.

l) Attendance at Manitoba Association of Optometrists Annual General Meeting.

APPROVED CREDIT: A maximum of 2 credit hours for attending the MAO Annual General Meeting – 1 credit hour for attendance for the entire morning portion of the meeting, and 1 credit hour for attendance for the entire afternoon portion of the meeting, provided that credit hours for attendance at the MAO Annual General Meeting are designated as practice management credit hours.

(13) Up to ten hours of approved credit, in excess of the required forty hours may be carried over to the following reporting period only.

(14) The Board of Examiners shall be the final authority regarding recognition of all continuing education credits.

21. COMPLAINTS, APPEALS & DISCIPLINE COMMITTEE APPOINTMENTS

Council shall appoint a Complaints Committee, an Appeals Committee and a Discipline Committee.

(1) The Complaints Committee shall be a standing committee of the Association, with members appointed annually, provided that Council shall also designate a roster of alternate Committee members to serve whenever necessary in the event of the inability or unavailability of a quorum of standing committee members to serve.

(2) The Appeals Committee shall be an ad hoc committee of the Association, with members appointed as required to deal with specific matters referred to the Committee.

(3) The Discipline Committee shall be an ad hoc committee of the Association, with members appointed as required to deal with specific matters referred to the Committee.

22. APPRAISAL COMMITTEE

(1) The Council shall appoint annually an Appraisal Committee composed of:

a) one member of the Council; and

b) two or more registered members who shall be practicing optometrists who are not members of Council.

(2) The Council shall name one of the members of the Appraisal Committee as the Chair.

(3) The Appraisal Committee shall report not less than once a year to Council and make recommendations to Council concerning the By-Laws of the Manitoba Association of Optometrists.

(4) The Appraisal Committee, for the purpose of examining and assessing the standards of practice in the profession and registered members' compliance with The Optometry Act, Regulation, and By-Laws of

the Manitoba Association of Optometrists (in this section "Manitoba Optometric Standards" means The Optometry Act, Regulation, and By-Laws of the Manitoba Association of Optometrists), may cause general inspections to be made by appointment and at reasonable hours of the records of registered members and the equipment used by them in the practice of optometry. The names of registered members selected for appraisal shall be determined by the Registrar and referred to the Appraisal Committee based on the following:

a) upon receipt of a complaint;

b) at random, at the request of Council;

c) at the request of the Registrar if there is reasonable cause to believe standards of practice are not being met;

d) at the request of Council for a registered member that has not provided 500 hours of direct patient care in any jurisdiction in the previous two years; and

e) upon receipt of a request from an optometrist for the purpose of evaluating their own practice.

The reason for referral will not be provided to the Appraisal Committee.

(5) In conducting an appraisal, the Appraisal Committee may delegate to any member of the Appraisal Committee the duty of appraising the practice.

(6) Upon completion of the appraisal, the Appraisal Committee shall send a report to the Registrar as to whether the registered member being appraised complies with Manitoba Optometric Standards.

(7) The Registrar will review the report of the Appraisal Committee and may review all documentation related to the appraisal, if necessary. The Registrar will confirm whether the registered member being appraised has met Manitoba Optometric Standards. If remediation is required, the Registrar will consult with the Chair of the Appraisal Committee on follow-up requirements.

(8) The Registrar shall send a letter to the registered member who was appraised, including a copy of the Appraisal Committee's report with the Registrar's comments and any requirements for remediation, noting the Registrar's decision as to whether the member's practice complies with Manitoba Optometric Standards.

(9) The Registrar may:

a) give instructions to the registered member who was appraised respecting desired improvements and the timeline to complete the improvements;

b) direct that the Appraisal Committee conduct a follow-up review to determine whether its instructions have been followed, and, if followed, whether the required changes have resulted in improvements being made within a reasonable time;

c) refer any of the following matters to the Complaints Committee for investigation:

   i. the refusal of a registered member to provide to the Appraisal Committee reasonable access to the records and equipment used by the registered member;

   ii. the failure of the registered member to follow the Registrar's instructions respecting desired improvements in their practice; and

   iii. any failure of the registered member to comply with The Act, Regulations or By-Laws, as determined by the Appraisal Committee.

(10) Within 30 days of receiving the final report from the Registrar, the registered member who was appraised may appeal the results or follow-up requirements to Council in writing. The registered member will be given opportunity to give written or oral representation to Council or have representations made to Council on their behalf. Council may confirm, alter or overturn the decision of the Registrar, or may refer back to the Registrar and Chair or the Appraisal Committee for further consideration.

(11) The Appraisal Committee, Council and any other paid employee of the Association shall neither use, nor disclose to any person the following:

a) practice appraisal reports and files;

b) files, papers, documents or records reviewed by an appraiser, the Appraisal Committee or Council; or

c) any other information obtained in the course of the appraisal except as may be required by law, the Act or Regulations.

(12) Appraisal Costs:

a) The cost of practice appraisals done at random or upon referral by the Complaints Committee shall be borne by the Association.

b) The cost of practice appraisals done at the request of a Discipline Committee shall be as determined by the Discipline Committee and shall be borne by the registered member.

c) The cost of practice appraisals done upon request of a registered member shall be as set out in the Schedule of Fees and shall be borne by the registered member making the request.

d) The cost of practice appraisals done at the request of Council for a registered member who has not provided 500 hours of direct patient care within the previous 2 years shall be as set out in the Schedule of Fees and shall be borne by the said registered member.

23. RIGHT TO REFUSE TREATMENT

(1) Except in an emergency, a registered member has the right to refuse treatment for either personal or professional reasons.

(2) A registered member having undertaken the care of a patient may not neglect the patient nor discontinue services without first having given notice in advance, where possible. The registered member must endeavour to arrange for continuity of treatment and for this purpose, provide the necessary information to whomever will take over the case.

24. PUBLIC DEALINGS OF OPTOMETRISTS

Public activities of registered members shall be of a professional and dignified nature so as not to bring the optometric profession into disrepute.

25. RENEWAL

(1) Dues and Fees shall be paid as required in the Act and the MAO By-Laws.

(2) Each year every registered member of the Association who wishes to renew their registration shall complete the membership renewal form as provided or amended by Council, a sample of which is marked as Appendix A hereto, and submit it to the registrar by December 15.

(3) a) In case of default in the payment of dues, the registered member's certificate may be revoked by the Council upon 30 days' notice.

b) Failure to complete and submit the following to the registrar:

i. the membership renewal form as described in Section 25(2);

ii. the report of continuing education and hours of direct optometric care as described in Sections 20(1) and 20(2);

iii. the criminal record information as described in Section 3(8); and,

iv. proof of liability insurance as described in Section 3(9);

by December 31 will result in non-renewal of membership and the registered member's registration will lapse. A lapsed membership that is not renewed by submitting the required documents, as described, by January 31, will not be renewed without reapplication for registration. All registration requirements and fees will apply.

(4) For each period for which a renewal of a permit for a professional corporation is required, the professional corporation shall complete the appropriate permit renewal form as provided or amended by Council, and submit it to the registrar with the fees established by Council and by the deadline established in this By-Law.

(5) Failure to complete and submit the permit renewal process as described in Section 25(4) will result in cancellation of the permit.

(6) All references to December in Section 25 refer to the December in advance of the commencement of the fiscal year.

26. CANADIAN ASSOCIATION OF OPTOMETRISTS

As a corporate member of the Canadian Association of Optometrists (CAO), the Manitoba Association of Optometrists is entitled to representation on the CAO Council.

The Association's representative to the CAO Council shall be appointed annually by Council at the meeting of Council immediately following the annual membership meeting.

27. AMENDMENTS OR NEW BY-LAWS

The By-Laws or any part thereof may be amended, repealed, added to, or other substituted in their stead, only after a written notice of motion, including for informational purposes a copy of the proposed wording, has been reviewed by the Legislative Committee, and has been sent at least thirty days previous to a meeting to all members of the Association. The assent of two-thirds of the registered members present shall be necessary for the adoption of such amendment, repeal, alteration or substitution.

28. AMENDMENT AND NAMING OF BY-LAWS

On any amendment of the By-Laws the name of the By-Laws should be automatically renumbered by the year and amendment number (e.g., 21/1).

Dr. Averi Van Dam, Optometrist
President

Dr. Adam Keech, Optometrist
Secretary-Treasurer

MANITOBA ASSOCIATION OF OPTOMETRISTS
MEMBERSHIP RENEWAL FORM

NOTE: Completion/update of Sections #1, 2, and 4-8 of this Form is mandatory for renewal of membership. Section #3 is voluntary. Registration, education and practice information is included in the MAO Optometrist Register and is therefore considered public. Practice Location 1 (your primary practice location) serves as your contact information on membership lists. Mailing address (if not a practice address) and home contact information will not be disclosed without member consent.

1. REGISTRATION/EDUCATION:

REGISTRATION #: **000** MEMBERSHIP STATUS: **Active** SURNAME:

DATE OF CURRENT ACTIVE REGISTRATION: NAME USED:

GIVEN NAMES: DATE OF BIRTH:

DRUG LICENCE: ACADEMIC DEGREES:

TPA LICENCE DATE: YEAR OF OD GRADUATION:

DPA LICENCE DATE: OD COLLEGE ATTENDED:

OD COLLEGE LOCATION:

2. MAO CONTACT INFORMATION:

MAILING ADDRESS:

,

HOME ADDRESS:

,

HOME PHONE:

CELL PHONE (OPTIONAL):

PRIMARY DAYTIME PHONE:

E-MAIL:

CONSENT TO SHARE:

FAX	**EMAIL**
☐ Other MAO Members	☐ Other MAO Members
☐ CAO Office	☐ CAO Office
☐ MB Ophthalmologists	☐ MB Ophthalmologists
☐ None of the Above	☐ None of the Above

I consent to MAO sending me communications at the email address I have provided. If I have given permission for my email address to be shared with Other MAO Members, the CAO Office, and/or MB Ophthalmologists, I further consent to other MAO Members, CAO and its affiliates, and/or MB Ophthalmologists sending me communications at the email address provided.

☐ By checking this box, I authorize MAO to use my home address to identify my electoral division/MLA, and to provide the name of my home riding to the Government Relations Committee for its information and communication with me.

3. OPTOMETRIC SERVICES PROVIDED (Check all services you offer at ANY of your practice locations)

- ◯ Automated Testing
  - ◯ refraction
  - ◯ keratometry
  - ◯ lensometry
- ◯ Automated Visual Fields
  - ◯ screening (FDT or similar)
  - ◯ threshold (Humphrey, Dicon, Medmont, Octopus, Synemed)
  - ◯ binocular (Esterman)
- ◯ Children's Eye Exams
  - ◯ 0-12 months ◯ 13-24 months
  - ◯ 2-3 years ◯ 3+ years
- ◯ Colour Vision
  - ◯ Pseudo-isochromatic plates
  - ◯ Farnsworth D15
- ◯ Contact Lenses
  - ◯ Orthokeratology
  - ◯ Scleral
- ◯ Contrast Sensitivity
- ◯ Gonioscopy
- ◯ Low Vision Therapy
- ◯ Ophthalmic Dispensing
- ◯ Ophthalmoscopy
  - ◯ direct
  - ◯ monocular indirect
  - ◯ binocular indirect
  - ◯ dilated fundus exam
- ◯ Pachymetry
- ◯ Perceptual Training
- ◯ Retinal Imaging
- ◯ Refractive Surgery - Pre and Post Op
- ◯ Stereo Acuity
- ◯ Tonometry
  - ◯ non contact
  - ◯ applanation
  - ◯ "Tonopen"
  - ◯ "iCare"
- ◯ Vision Therapy (Orthoptics)
  - ◯ office
  - ◯ home
  - ◯ patching therapy
- ◯ Visits to Reserves
- ◯ Visits to Homes and Nursing Homes
  - ◯ Only to care homes, hospitals, institutions
  - ◯ Also to individual residences (house/apt)

◯ Other:

◯ Show me as accepting diabetic patients on MAO website. ◯ Show me as accepting pediatric patients on MAO website.

4.a) PRACTICE LOCATIONS - ALL PRACTICE LOCATIONS MUST BE LISTED

"Practice Location" means a permanent location where optometric care is regularly offered on a schedule generally known to the public. Appointments are available to the public.

Location # 1

PRACTICE NAME:

☐ Regular: LIST ON MAO WEBSITE'S FIND AN OPTOMETRIST
☐ Occasional: DO NOT LIST on MAO website's Find an Optometrist

ADDRESS

PHONE

FAX

OFFICE OPEN:

YOU WORK THERE:

WEBSITE

SERVICES AVAILABLE:

☐ OVC ☐ Corneal Topography
☐ OCT ☐ Optomap
☐ Threshold Visual Fields
☐ Languages in addition to English:
Specify:

☐ Wheelchair Accessible, details:
☐ Manual wheelchairs (standard size)
☐ Larger wheelchairs (electric)
☐ Exam in wheelchair
☐ Chair transfer aide required
☐ Patients should call ahead

☐ Solo Practice
Your Associates:

Salaried ODs:

☐ Partnership
Your Partners:
Your Associates:

Salaried ODs:

☐ Associate
To Whom:

☐ Salaried
Employer:

THIRD PARTY PRACTICE ASSOCIATION: At this location, do you lease, share, or use practice premises controlled by an optician, optical retail, general retail, optical management or associated holding company?

☐ YES ☐ NO

IF YES, Name of Company:

Location # 2

PRACTICE NAME:

☐ Regular: LIST ON MAO WEBSITE'S FIND AN OPTOMETRIST
☐ Occasional: DO NOT LIST on MAO website's Find an Optometrist

ADDRESS

PHONE

FAX

OFFICE OPEN:

YOU WORK THERE:

WEBSITE

SERVICES AVAILABLE:

☐ OVC ☐ Corneal Topography
☐ OCT ☐ Optomap
☐ Threshold Visual Fields
☐ Languages in addition to English:
Specify:

☐ Wheelchair Accessible, details:
☐ Manual wheelchairs (standard size)
☐ Larger wheelchairs (electric)
☐ Exam in wheelchair
☐ Chair transfer aide required
☐ Patients should call ahead

☐ Solo Practice
Your Associates:

Salaried ODs:

☐ Partnership
Your Partners:
Your Associates:

Salaried ODs:

☐ Associate
To Whom:

☐ Salaried
Employer:

THIRD PARTY PRACTICE ASSOCIATION: At this location, do you lease, share, or use practice premises controlled by an optician, optical retail, general retail, optical management or associated holding company?

☐ YES ☐ NO

IF YES, Name of Company:

Location # 3

PRACTICE NAME:

☐ Regular: LIST ON MAO WEBSITE'S FIND AN OPTOMETRIST
☐ Occasional: DO NOT LIST on MAO website's Find an Optometrist

ADDRESS

PHONE

FAX

OFFICE OPEN:

YOU WORK THERE:

WEBSITE

SERVICES AVAILABLE:

☐ OVC ☐ Corneal Topography
☐ OCT ☐ Optomap
☐ Threshold Visual Fields
☐ Languages in addition to English:
Specify:

☐ Wheelchair Accessible, details:
☐ Manual wheelchairs (standard size)
☐ Larger wheelchairs (electric)
☐ Exam in wheelchair
☐ Chair transfer aide required
☐ Patients should call ahead

☐ Solo Practice
Your Associates:

Salaried ODs:

☐ Partnership
Your Partners:
Your Associates:

Salaried ODs:

☐ Associate
To Whom:

☐ Salaried
Employer:

THIRD PARTY PRACTICE ASSOCIATION: At this location, do you lease, share, or use practice premises controlled by an optician, optical retail, general retail, optical management or associated holding company?

☐ YES ☐ NO

IF YES, Name of Company:

Location # 4

PRACTICE NAME:

☐ Regular: LIST ON MAO WEBSITE'S FIND AN OPTOMETRIST
☐ Occasional: DO NOT LIST on MAO website's Find an Optometrist

ADDRESS

PHONE

FAX

OFFICE OPEN:

YOU WORK THERE:

WEBSITE

SERVICES AVAILABLE:

☐ OVC ☐ Corneal Topography
☐ OCT ☐ Optomap
☐ Threshold Visual Fields
☐ Languages in addition to English:
Specify:

☐ Wheelchair Accessible, details:
☐ Manual wheelchairs (standard size)
☐ Larger wheelchairs (electric)
☐ Exam in wheelchair
☐ Chair transfer aide required
☐ Patients should call ahead

☐ Solo Practice
Your Associates:

Salaried ODs:

☐ Partnership
Your Partners:
Your Associates:

Salaried ODs:

☐ Associate
To Whom:

☐ Salaried
Employer:

THIRD PARTY PRACTICE ASSOCIATION: At this location, do you lease, share, or use practice premises controlled by an optician, optical retail, general retail, optical management or associated holding company?

☐ YES ☐ NO

IF YES, Name of Company:

4.a) Practice Locations continued

Location # 5 PRACTICE NAME:

☐ Regular: LIST ON MAO WEBSITE'S FIND AN OPTOMETRIST
☐ Occasional: DO NOT LIST on MAO website's Find an Optometrist

ADDRESS

PHONE

FAX

OFFICE OPEN:

YOU WORK THERE:

WEBSITE

SERVICES AVAILABLE:
☐ OVC ☐ Corneal Topography
☐ OCT ☐ Optomap
☐ Threshold Visual Fields
☐ Languages in addition to English: Specify:

☐ Wheelchair Accessible, details:
☐ Manual wheelchairs (standard size)
☐ Larger wheelchairs (electric)
☐ Exam in wheelchair
☐ Chair transfer aide required
☐ Patients should call ahead

☐ Solo Practice
Your Associates:
Salaried ODs:
☐ Partnership
Your Partners:
Your Associates:
Salaried ODs:
☐ Associate
To Whom:
☐ Salaried
Employer:

THIRD PARTY PRACTICE ASSOCIATION: At this location, do you lease, share, or use practice premises controlled by an optician, optical retail, general retail, optical management or associated holding company?
☐ YES ☐ NO
IF YES, Name of Company:

Location # 6 PRACTICE NAME:

☐ Regular: LIST ON MAO WEBSITE'S FIND AN OPTOMETRIST
☐ Occasional: DO NOT LIST on MAO website's Find an Optometrist

ADDRESS

PHONE

FAX

OFFICE OPEN:

YOU WORK THERE:

WEBSITE

SERVICES AVAILABLE:
☐ OVC ☐ Corneal Topography
☐ OCT ☐ Optomap
☐ Threshold Visual Fields
☐ Languages in addition to English: Specify:

☐ Wheelchair Accessible, details:
☐ Manual wheelchairs (standard size)
☐ Larger wheelchairs (electric)
☐ Exam in wheelchair
☐ Chair transfer aide required
☐ Patients should call ahead

☐ Solo Practice
Your Associates:
Salaried ODs:
☐ Partnership
Your Partners:
Your Associates:
Salaried ODs:
☐ Associate
To Whom:
☐ Salaried
Employer:

THIRD PARTY PRACTICE ASSOCIATION: At this location, do you lease, share, or use practice premises controlled by an optician, optical retail, general retail, optical management or associated holding company?
☐ YES ☐ NO
IF YES, Name of Company:

Location # 7 PRACTICE NAME:

☐ Regular: LIST ON MAO WEBSITE'S FIND AN OPTOMETRIST
☐ Occasional: DO NOT LIST on MAO website's Find an Optometrist

ADDRESS

PHONE

FAX

OFFICE OPEN:

YOU WORK THERE:

WEBSITE

SERVICES AVAILABLE:
☐ OVC ☐ Corneal Topography
☐ OCT ☐ Optomap
☐ Threshold Visual Fields
☐ Languages in addition to English: Specify:

☐ Wheelchair Accessible, details:
☐ Manual wheelchairs (standard size)
☐ Larger wheelchairs (electric)
☐ Exam in wheelchair
☐ Chair transfer aide required
☐ Patients should call ahead

☐ Solo Practice
Your Associates:
Salaried ODs:
☐ Partnership
Your Partners:
Your Associates:
Salaried ODs:
☐ Associate
To Whom:
☐ Salaried
Employer:

THIRD PARTY PRACTICE ASSOCIATION: At this location, do you lease, share, or use practice premises controlled by an optician, optical retail, general retail, optical management or associated holding company?
☐ YES ☐ NO
IF YES, Name of Company:

4.b) ITINERANT PRACTICE LOCATIONS

"Itinerant Practice Location" means a location where optometric care is offered on a non-predictable basis, or offered at a non-optometric address. Appointments may or may not be available to the public. Examples include: CNIB, temporary locations on reserves, temporary locations in remote communities, laser clinics, ophthalmology practices where optometric services are not offered, etc. A mobile clinic is also an Itinerant Practice Location, but must be reported in section 4.c).

FACILITY/AGENCY	ADDRESS	PHONE

4.c) MOBILE CLINICS (If you have more than 1 mobile clinic, details of your additional clinics must be attached on a separate page)

MOBILE CLINIC NAME ADDRESS PHONE	☐ Solo Practice **Your Associates:** **Salaried ODs:** ☐ Partnership with: **Your Associates:** **Salaried ODs:**
THIRD PARTY PRACTICE ASSOCIATION: Do you lease, share, or use mobile clinic equipment or resources controlled by an optician, optical retail, general retail, optical management or associated holding company? ☐ YES IF YES, Name of Company: ☐ NO	☐ Associate **To Whom:** ☐ Salaried **Employer:**

5. DISPENSARY

6. CRIMINAL RECORD CHECK

Members whose current registration with the Association commenced in a year ending with 5 (e.g. 1975) or 0 (e.g. 1990) must submit a Criminal Record Check with Vulnerable Sector Search this year.
All other members must confirm whether he or she has been convicted of a criminal offense and, if he or she has been convicted, provide information regarding that conviction to the Board of Examiners.

Your Registration Date for the purposes of Criminal Record Checks is:

☐ I am required to submit a Criminal Record Check with Vulnerable Sector Search this year. I am enclosing my Criminal Record Check or have already submitted it to the MAO office.

☐ I am not required to submit a Criminal Record Check this year. By checking this box, I certify that I have no criminal convictions, or if I do have one or more convictions, that I have already reported details of all convictions to MAO.

☐ I am not required to submit a Criminal Record Check this year, but I have one or more convictions that I have not yet reported to MAO. I am enclosing details of my conviction(s) in a separate sealed envelope marked "Conviction Details Confidential."

7. PROFESSIONAL LIABILITY INSURANCE

All Members must submit proof of current professional liability insurance with annual renewal of registration.

☐ I am enclosing a copy of my professional liability insurance certificate or have already submitted it to the MAO office.

☐ I am emailing a copy of my professional liability insurance certificate to mao@mb-opto.ca.

8. CERTIFICATION AND SIGNATURE

Sections #1, 2, and 4-8 are mandatory for renewal of membership.
Section #3 is voluntary but is helpful so the MAO office can provide information to the public and other optometrists.
By completing Section #3, I give consent for MAO to share this information.

By signing below, I certify that I have personally reviewed the information in this Membership Renewal Form and that all the information is true, accurate and complete. I understand that, in accordance with the MAO Bylaws, any changes to my practice circumstances must be reported to MAO within 7 days of the change.

_____ _____

DATE **SIGNATURE**

DO YOU HAVE ANY COMMENTS ABOUT ASSOCIATION ACTIVITIES OR PRIORITIES?

i.e. what should MAO and its Council and Committees be doing more of? less of? better? (attach separate page if necessary)

APPENDIX B TO MAO BY-LAWS

SCHEDULE OF FEES

1)	Jurisprudence examination	$200
2)	Re-issue of a registration certificate after revocation or lapse	$200
3)	Optometric student (clerkship/externship) registration	$50
4)	Re-write of Jurisprudence examination	$200
5)	Appeal of refusal to register (refundable if successful)	$200
6)	Application for registration	$200
7)	Registration certificate	$25
8)	Drug licence	$25
9)	Practice appraisal at the request of a registered member	$250
10)	Practice appraisal for a registered member who has not provided 500 hours of direct patient care within the previous 2 years;	$250
11)	Application for registration of professional corporation	$350
12)	Professional corporation permit (initial or renewal)	$150
13)	Default of payment of membership dues, including late payment and NSF/returned cheque. In the case of returned cheques, actual bank charges will also be billed.	$200
14)	Late fee – renewal of professional corporation permit	$50
15)	NSF/returned cheque fee for all payments except dues. Actual bank charges will also be billed.	$40
16)	Late fee – continuing education/convention registration	$50

+ GST where applicable

PART-TIME MEMBERSHIP IS ANNUAL & SUBJECT TO COUNCIL APPROVAL

To continue as a PT Member, you must re-apply with your annual membership renewal ***every part-time year***

MEMBER APPLICATION FOR REDUCTION IN ASSOCIATION FEES

APPENDIX C

RE: PART-TIME MEMBERSHIP

I hereby request the Council of the Manitoba Association of Optometrists, in accordance with the powers granted to it under the Optometry Act, Regulations and By-Laws, to adjust my dues to the amount payable by a part-time member.

As a condition to this application I hereby undertake and agree to:

(1) limit the amount of my time devoted to the practice of optometry in any jurisdiction to a total of 100 or fewer days during the period of **January 1, 2024 to December 31, 2024**;

(2) maintain an up-to-date record of the days I spend in the practice of optometry and to provide a copy of that record to Council upon request; and

(3) maintain my continuing education requirements as specified in the Optometry Act, Regulations, and By-Laws.

I understand and agree that acceptance by Council of this application and the consequent reduction of my membership fees shall not in any way alter my rights nor my responsibilities as a registered optometrist or an authorized entity in accordance with the Optometry Act, Regulations and By-Laws.

My full name is _____
(please print)

Signed at _____ this _____ day of _____ 20___.

SIGNATURE: _____ OD

MANITOBA ASSOCIATION OF OPTOMETRISTS

ADVERSE DRUG REACTION
Ocular/Systemic

Patient Code: ..... Patient Age: ..... M ___ F ___

Optometrist Name: ..... Phone: .....

Address: .....

DRUG INSTILLED:

Generic Name: ..... Strength: ..... % / mg

Trade Name: ..... Dosage (# of drops): O.D. ___ O.S. ___

Drug Lot #: ..... Expiry Date: .....

Route of Administration: .....

Reason for Drug Instillation: .....

Date of Instillation: ..... Time: .....

Interaction time of onset, duration, intensity: .....

PATIENT HISTORY:

Patient Ophthalmic Drug History: (Dx or Tx) .....

Patient Medical History: .....

Patient Allergic History: .....

Patient Systemic Drug Treatment History: .....

Foods/Beverages ingested (up to 6 hours prior to interaction): .....

Other and Environmental Factors: .....

Details of Preliminary Ocular work-up (Pre-instillation): .....

.....

DETAIL DESCRIPTION OF ADVERSE ACTION:

Ocular.....

Systemic .....

Treatment Administered: Ocular.....

Systemic.....

PATIENT DISPOSITION:

Was informed consent for proposed treatment received? Yes __ No __ If Yes, Verbal or Written?

Were risks disclosed to patient prior to proposed treatment? Yes __ No __ If Yes, Verbal or Written?

Was patient's physician notified about this drug reaction? Yes __ No __ If Yes, Verbal or Written?

Patient referral to: (if any) .....

Address: .....

(If a drug prescription was issued, please attach copy)