ALBERTA OPTICIANS ASSOCIATION
NOTIFICATION
OF OPTICAL STORE CLOSURE
IN ALBERTA

Registrant's Name: _____
First Middle Last

Registration Number: _____

THIS NOTICE SERVES TO INFORM THE ALBERTA OPTICIANS ASSOCIATION OF THE CLOSURE OF:

_____
Business Name

_____
Unit # Building Name, Street Number and Name

_____ _____
City Prov. Postal Code Country

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

Date of Closure is effective starting on: _____
YYYY / MM / DD

PATIENT FILE MANAGEMENT

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

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ACTIONS TAKEN TO NOTIFY PATIENTS OF NEW FILE LOCATION

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