Eye Canada Information Request Form:

Name:________________________________Date:___________________________

Best Time to Contact: Day(s):___________________Time:___________________

Clinic Name:_______________________

Address:_________________City:_______________Postal Code:______________

Phone:________________________________Email:_________________________

Name of Partners:	Name of Associates:
1.______________________	1.______________________
2.______________________	2.______________________
3.______________________	3.______________________
4.______________________	4.______________________

Approximate Number of Patient Visits Per Year:_____________________

Do you currently, or have you in the past provided low vision services?

Yes No

IF Yes, Please provide details:____

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Please list any further comments or questions: ____________________________

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Please Fax to 1-204-487-3458 and an Eye Canada Representative will Contact You