College of Pharmacists of British Columbia

APPLICATION FOR

LIMITED PHARMACIST REGISTRATION

APPLICANT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal Name _____

Last name (Surname) *First name* *Middle name*

Address _____ Tel *(home)* _____

_____ Tel *(work)* _____

_____ Email _____

City *Province*

_____ eServices ID _____

Postal code *Country*

Pursuant to s. 54(2) of the *Health Professions Act Bylaws*, a registrant **must** notify the registrar immediately of any change of name, address, telephone number, electronic mail address, names and address of the pharmacies where the registrant provides pharmacy services, or any other registration information previously provided to the registrar.

Registrants can update their contact information using the eServices section of our website.I attest that I am in compliance with the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

I have professional liability insurance that meets the following criteria and I understand that I must obtain and maintain it at all times while registered as a Limited Pharmacist*:*

- Provides a minimum of $2 million coverage.
- Provides occurrence based coverage or claims made with extended reporting period of at least 3 years.
- If not in the pharmacist's name, the group policy covers the pharmacist as an individual.

_____ _____

Date Applicant signature

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the *Pharmacy Operations and Drug Scheduling Act*, *Health Professions Act*, and *Freedom of Information and Protection of Privacy Act*. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org

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Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ , declare that *(check the appropriate boxes)*:

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make my registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC:

- *a charge relating to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs, or relating to any criminal offense;*
- *a finding of guilt in relation to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above is not true (i.e. if any of the above boxes is not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

_____ _____

Date Applicant Signature

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Pharmacist Confidentiality Undertaking

I agree to access the **PharmaNet** clinical and patient database through the in-pharmacy computer system, on the following terms and conditions:

☐ I will not access or use any clinical or patient information in the PharmaNet database or the in-pharmacy computer system for any purpose other than those authorized by the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act and the Bylaws of the College of Pharmacists of BC made pursuant to these Acts.

☐ I agree at all times to treat as confidential all information referred to in paragraph (1) and will not participate in or permit, the unauthorized release, publication or disclosure of the said information to any person, corporation or other entity under any circumstances except as authorized by the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act and the Bylaws of the College of Pharmacists of BC made pursuant to these Acts.

☐ I agree at all times, to treat as confidential all information relating to the security and management of the PharmaNet database and the in-pharmacy computer system.

☐ I agree to be bound by the provisions of this agreement and will continue to do so following termination of employment in the pharmacy for any reason.

☐ I agree to adhere to all policies and procedures issued by the pharmacy manager and/or the pharmacy owner, consistent with legislation, policies, procedures and standards issued by the College of Pharmacists of British Columbia or the Province of British Columbia, related to the confidentiality, privacy and security of the patient or clinical information contained in the PharmaNet database and the in-pharmacy computer database.

_____ _____

Date Applicant signature

Note:

1. *Attach original with application for registration.*
2. *Make a copy for the pharmacy manager - to be retained in the pharmacy files.*

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Criminal Record Check Authorization

APPLICANT INFORMATION

Legal name _____
Last name (Surname) *First name* *Middle name*

Mailing address _____
Street *City/Town* *Province/State* *Postal Code*

_____ Contact phone _____
Country *Area code*

Gender ☐ Male ☐ Female B.C. Driver's Licence # _____

Birthdate _____ Birthplace _____
YYYY-MM-DD *City/town* *Province/State* *Country*

Other names used or have used *(e.g. maiden name, birth name, previous married name, informal name)*

1. _____
Surname *First name* *Middle name*
2. _____
Surname *First name* *Middle name*
3. _____
Surname *First name* *Middle name*

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA)

The information requested on this form is collected under the authority of the Criminal Records Review Act and in the case of child care facilities, the Community Care and Assisted Living Act, and the regulations which govern both these acts. The information provided will be used to fulfill the requirements of the Criminal Records Review Act for the release of criminal records information and is in compliance with the FOIPPA.

CONSENT FOR RELEASE OF INFORMATION AND ACKNOWLEDGEMENTS

Pursuant to the B.C. Criminal Records Review Act

Consent information can be found at:

http://www.bcpharmacists.org/library/3_Registration_Licensure/5144-CRC_Consent_Release_Information_Acknowledgement.pdf

Contact the College office if you cannot access the consent information.

- I have read and understood the Consent for Release of Information and Acknowledgements above. I hereby consent to these terms as indicated by my signature below.
- I hereby authorize the College of Pharmacists of British Columbia to conduct criminal record checks on an ongoing basis at least once every five years. I understand that I may withdraw this consent for future criminal record checks.

_____ _____
Date Applicant signature

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PAYMENT OPTION

Applicant Name _____
Last name (Surname) *First name* *Middle name*

☐ Bank Draft/Money order
(payable to College of Pharmacists of BC)

☐ VISA ☐ MasterCard

Card # _____ Exp ____ /____

Cardholder name _____

Cardholder signature _____

Registration fee	739.00
Criminal Record Check fee	28.00
GST	36.95
Total	**$ 803.95**

GST # R106953920

For office use ONLY

iMIS ID: Finance stamp:

Reg initials:

Date to Finance: