College of Pharmacists of British Columbia

APPLICATION FOR

CERTIFICATION – DRUG ADMINISTRATION

APPLICANT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal Name _____

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

Address _____ Tel *(home)* _____

_____ Tel *(work)* _____

_____ Email _____

City *Province*

_____ Reg # _____

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 the Acts.

I have attached:

- Signed declaration form (page 2)
- Copy of certificates of completion of training from a College approved accredited program in the administration of drugs by injection and intranasal route.
- Copy of certificates of completion of training in first aid and CPR.

_____ _____

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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Declaration Form

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
MY APPLICATION TO THE COLLEGE OF PHARMACISTS OF BC
FOR CERTIFICATION –DRUG ADMINISTRATION BY INJECTION AND INTRANASAL ROUTE

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

- ☐ 1. I am the person referred to in the documents submitted in support of my application, and that these documents present a true and accurate account of my qualifications.
- ☐ 2 I am registered with the College of Pharmacists of British Columbia.
- ☐ 3. I will abide by the standards, limits and conditions that apply to the administration of drugs by injection and intranasal route, and restrict my practice to those areas in which I am competent.
- ☐ 4. I have successfully completed an education program in administering a drug by injection and intranasal route, approved by the board of the College.
- ☐ 5. I have successfully completed training in first aid and CPR and will maintain valid first aid certification and CPR certification for the duration of my drug administration certification, and that if I am unable to provide proof of certification, my certification to administer drugs by injection and intranasal route will be cancelled.
- ☐ 6. I will engage in the restricted activity of administering drugs by injection and intranasal route only after having received approval from the College of Pharmacists of British Columbia.
- ☐ 7. The status of my eligibility for certification is subject to audit and that false or misleading statements concerning my qualifications may be considered grounds for a complaint of unprofessional conduct.

I make this declaration, conscientiously as it to be true and knowing that it is of the same force and effect as if made under oath.

_____ _____

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 _____

Application fee	105.00
GST	5.25
Total	**$ 110.25**

GST # R106953920

For office use ONLY

iMIS ID: _____ Finance stamp:

Reg initials: _____

Date to Finance: _____