



APPLICATION FOR CERTIFICATION – DRUG ADMINISTRATION

HPA Form 13

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To apply for Drug Administration Certification, complete this form and submit it along with the required documents to the College's Registration Department by email at: registration@bcpharmacists.org or by fax at: 604-733-2493. Ensure all documents are scanned in accordance with the College's [Scanning Guidelines and Checklist for Document Submissions](#) prior to submission.

| 1. APPLICANT INFORMATION | | |
|--|--|---------------------------|
| <input type="checkbox"/> eServices ID or <input type="checkbox"/> CPBC Registration Number | <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. | Legal Last Name (Surname) |
| Legal First Name | Legal Middle Name | Informal Name (if any) |

| 2. CONTACT INFORMATION | | |
|---------------------------------------|---------------------|---------|
| Street Address (Include Unit/Suite #) | | City |
| Province | Postal Code | Country |
| Phone Number (Home) | Phone Number (Work) | Email |

| 3. TRAINING INFORMATION | |
|---|------------------------|
| Education Program in Drug Administration (Select One) | |
| <input type="checkbox"/> Completed a program approved by the Board in Schedule C of HPA Bylaws – Attach the Certificate of Completion with this application. <input type="checkbox"/> Completed training as part of a Baccalaureate or Pharm.D (entry level) pharmacy program accredited by the Canadian Council for Accreditation of Pharmacy Programs – Provide name of university and course #: _____ <input type="checkbox"/> Completed training previously and currently possess valid Drug Administration Certification (or equivalent) with another Canadian pharmacy regulatory body – Provide name of pharmacy regulatory body: _____ and order a Letter of Standing (LOS) to be sent directly to the College. The LOS should indicate that you currently have valid drug administration certification. | |
| Completion Date of First Aid | Completion Date of CPR |

| 4. DECLARATION | |
|---|---|
| I declare that the following and the facts set out herein to be true (check the appropriate boxes): | |
| <input type="checkbox"/> | 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. |
| <input type="checkbox"/> | 2. 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. |
| <input type="checkbox"/> | 3. I will maintain valid first aid certification and CPR certification for the duration of my drug administration certification. I understand that I must report to the College if I do not maintain valid first aid and CPR certification, or if I am unable to provide proof of certification, my drug administration certification will no longer be valid and I must cease from administering drugs via injection and intranasal route immediately until I am recertified by the College. |
| <input type="checkbox"/> | 4. 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. |
| <input type="checkbox"/> | 5. 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.

| | |
|---------------------|--------------------|
| Applicant Signature | Date (MMM-DD-YYYY) |
|---------------------|--------------------|

The College collects personal information on this application form to process the application and administer the College's related activities. The collection of this information is authorized under section 26(c) of the *Freedom of Information and Protection of Privacy Act (the Act)*. The College is authorized to use this information as per section 32(a) of the Act and may also disclose information in other circumstances when authorized by the Act or other legislation. Further information regarding the collection, use and disclosure of personal information can be found in the privacy policy posted on the College website: <https://www.bcpharmacists.org/privacy>. Should you have any questions about the collection, use or disclosure of this information, please contact our Privacy Officer at: privacy@bcpharmacists.org or 778-330-0969.

Initial



4. PAYMENT INFORMATION

Applicant Name (Full Legal Name)

Method of Payment: Bank Draft/Money order (payable to College of Pharmacists of BC) VISA MasterCard

| | | |
|----------------------|---------------------|---|
| Card Number | Expiry Date (MM-YY) | Application fee \$ 115.00 GST \$5.75 Total \$ 120.75 GST # R106953920 |
| Cardholder Name | | |
| Cardholder Signature | | |

For office use ONLY

iMIS ID: _____ Finance stamp: _____

Reg initials: _____

Date to Finance: _____

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