College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF INDIRECT OWNER(S)

Form 8B

1. CURRENT PHARMACY INFORMATION

Operating Name			Pharmacy Licence Number	
Pharmacy Address	**City**		**Province** BC	**Postal Code**
Email Address	**Phone Number**		**Fax Number**	
Manager Name			**Manager's Registration Number (BC)**	

2. DEPARTING INDIRECT OWNER(S)

Type	Company/Corporation Name	Name of Indirect Owner	Pharmacist (Y/N)	Effective Date of Change
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY

*If known

3. NEW INDIRECT OWNER(S)

Type	Company/Corporation Name	Name of Indirect Owner	Pharmacist (Y/N)	Effective Date of Change
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY

*If known

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4. ADDITIONAL INFORMATION

As a result of this change (indirect owner):

a)	Will the **pharmacy operating name** or **external signage name** also be changed at the same time?	☐ Yes – Also complete **Form 8E**	☐ No
		☐ Yes – Also complete **Form 8G**	☐ No
b)	Will the **pharmacy layout** also be changed at the same time?	☐ Yes – Also complete **Form 9**	☐ No
c)	Will **other pharmacies** be affected by the same change?		

5. APPLICANT (DIRECT OWNER) INFORMATION

Name of Authorized Representative	**Position/Title of Authorized Representative**	
Email Address	**Phone Number**	**Fax Number**
Signature	**Date** MMM | DD | YYYY	

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