APPLICATION FOR HOSPITAL SATELLITE

APPLICANT INFORMATION

Company name ______________________

Central pharmacy ______________________

Pharmacy manager ______________________

Address ______________________ Tel ____________

______________________ Fax ____________

______________ ________ Email ____________

Postal Code

PROPOSED REMOTE SITE

Remote site address, including name of pharmacy ______________________ Tel ____________

______________________ Fax ____________

______________________ Email ____________

______________ ________

Postal Code

Hours of operation for Satellite ______________________

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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 addresses 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:

- The Pharmacy is 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 read and understood the Pharmacy Licensure in British Columbia – Information Guide and Resources package.

______________________ Name (please print)

______________________ Signature

______________________ Position

______________________ Date

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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APPLICATION REQUIREMENT CHECKLIST

Application must be received by the College Office <u>at least 60 business days</u> prior to the planned operation of the hospital satellite.

Application must be approved PRIOR to commencement of hospital satellite service.

The following must be submitted together with this application:

- Diagram detailing the layout of the hospital pharmacy satellite

PharmaNet connection for both sites? ☐ Yes ☐ No

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PAYMENT OPTION

Pharmacy Name ____

☐ Cheque/Money order *(payable to College of Pharmacists of BC)* ☐ VISA ☐ MasterCard

Card # ______________________________ Exp _____ /______

Cardholder name ______________________________

Cardholder signature ______________________________

Initial licence fee	300.00
GST	15.00
Total	**$315.00**

GST # R106953920

For office use ONLY

iMIS ID: ____________ Finance stamp:

Lic initials: ____________

Date to Finance: ____________