



APPLICATION FOR NON-PRACTISING PHARMACIST REGISTRATION

APPLICANT INFORMATION

Ms
 Mrs
 Miss
 Mr
 Dr

Reg # _____

Name _____
Last name (Surname) First name Other name(s)

Address _____ **Tel (home)** _____

_____ **Tel (work)** _____

_____ **Email** _____
City Province

_____ Postal code Country

PAYMENT OPTION

Cheque/Money order (payable to College of Pharmacists of BC)

VISA MasterCard

Card # _____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Registration fee	504.00
HST	<u>60.48</u>
Total	<u>\$564.48</u>
<small>HST # R106953920</small>	

All fees are non-refundable and subject to HST.

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 signed and attached:

- Statutory Declaration (use form on page 2).
- Criminal Record Check Authorization (use form on page 3).

_____ Date

_____ Applicant signature

**APPLICATION FOR****NON-PRACTISING PHARMACIST REGISTRATION****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 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



APPLICATION FOR NON-PRACTISING PHARMACIST REGISTRATION

Criminal Record Check Authorization

APPLICANT INFORMATION

Legal name _____
Last name (Surname) First name Other name(s)

Mailing address _____
Street City/town Province/State Postal Code

_____ **Contact phone** _____
Country Area code

Gender Male Female B.C. Driver License _____

Birth date _____ Birthplace _____
YYYY-MM-DD City/town Province/State Country

Other names used or have used (e.g. maiden name, birth name, previous married 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 Facility 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

- I hereby consent to a check for records of criminal convictions to determine whether I have a conviction or outstanding charge for any relevant offences under the Criminal Records Review Act.
- I hereby authorize the release to the Deputy Registrar any documents in the custody of the police, the court and crown counsel relating to an outstanding charge or conviction of any relevant offence as defined under the Criminal Records Review Act
- Where the results of this check indicate that a criminal record or outstanding charge for a relevant offence may exist, I agree to provide my fingerprints to verify any such criminal record.
- The Deputy Registrar will notify me and my organization that I have an outstanding charge or conviction for any relevant offence(s) and the matter has been referred to the Deputy Registrar.
- The Deputy Registrar will determine whether or not I present a risk to physical or sexual abuse to children.
- The Deputy Registrar's determination will be disclosed to my organization and it will include consideration of any relevant offence for which I have received a pardon.
- If I am charged with or convicted of a relevant offence at any time subsequent to the criminal record check authorized herein, I further agree to report the charge or conviction to my organization and provide my organization, in a timely manner, with a new-signed Consent to a Criminal Record Check form.

"Deputy Registrar" means a person appointed under the Public Service Act as deputy registrar for the purposes of this Act.

CONSENT TO RELEASE OF INFORMATION AND ACKNOWLEDGEMENTS

- 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 every five years. I understand that I may withdraw this consent for future criminal record checks.

Date

Applicant signature