



**APPLICATION FOR REINSTATEMENT**  
LESS THAN 6 YEARS IN NON-PRACTISING OR FORMER PHARMACIST REGISTER

## CHECKLIST

### You must submit

1.  Checklist *(page 1)*.
2.  Application form *(page 2)*.
3.  Notarized identification *(use form on page 3)*.
4.  Statutory declaration *(use form on page 4)*.
5.  Criminal record check authorization *(use form on page 5)*.

### You must submit IF

6.  Evidence of your authorization to work in Canada – if you are not a Canadian citizen or a permanent resident. Acceptable documents: Canadian citizenship card, Canadian passport, permanent resident card, social insurance card, or work permit.
7.  A letter/certificate of standing from **each** regulatory body - if you have engaged in the practice of pharmacy or another health profession in another jurisdiction. Letter/certificate must be dated within three months prior to the date of the application and must be mailed to the college office directly from the regulatory bodies.

**Photocopy both sides of documents where applicable.**  
**Documents in a language other than English must be translated by a government official or an official translator.**



# APPLICATION FOR REINSTATEMENT LESS THAN 6 YEARS IN NON-PRACTISING OR FORMER PHARMACIST REGISTER

## Application Form

### CONTACT INFORMATION

Ms     Mrs     Miss     Mr     Dr

Legal name \_\_\_\_\_  
Last name (Surname)                      First name                      Other name(s)

Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
City    Province

\_\_\_\_\_ Postal code                      Country

Tel (home) \_\_\_\_\_  
 Tel (work) \_\_\_\_\_  
 Email \_\_\_\_\_

### REQUIRED FEES

- Reinstatement fee.
- Criminal Record Check fee.
- PDAP Knowledge Assessment (KA) fee.\*

\* The full amount can be applied towards your annual registration fee if you meet the PDAP standards and reinstate within one year of this application.

### PAYMENT OPTION

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

VISA     MasterCard

Card # \_\_\_\_\_ Exp \_\_\_\_ / \_\_\_\_

Cardholder name \_\_\_\_\_

Cardholder signature \_\_\_\_\_

Reinstatement fee *	282.50
PDAP KA fee	525.00
HST	96.90
<b>Total</b>	<b>\$904.40</b>
<small>HST # R106953920</small>	

\* Includes criminal record check

**All fees are non-refundable and subject to HST.**

I hereby authorize the release of my PDAP status in support of this application for reinstatement.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant signature



# APPLICATION FOR REINSTATEMENT

## LESS THAN 6 YEARS IN NON-PRACTISING OR FORMER PHARMACIST REGISTER

### Notarized Identification

#### APPLICANT INFORMATION

Applicant name \_\_\_\_\_

#### Required Documents

Passport photograph, taken within one year, affixed to space provided.

Copy of name change or marriage certificate if name on any document is different from legal name.

#### Required identification - one primary and one secondary.

Identification presented to the Notary Public must be the **original** document issued by the government agency. Photocopies are acceptable only if certified by the issuing government agency to be true copies of the original.



PRIMARY		SECONDARY	
Document type	Document number	Document type	Document number
<input type="checkbox"/> Birth certificate		<input type="checkbox"/> Passport	
<input type="checkbox"/> Canadian citizen card		<input type="checkbox"/> Valid Canadian driver's license	
<input type="checkbox"/> Canadian identity card		<input type="checkbox"/> British Columbia identification card	
		<input type="checkbox"/> Naturalization certificate	
		<input type="checkbox"/> Canadian Forces identification	

\_\_\_\_\_ Date

\_\_\_\_\_ Applicant signature

#### NOTARY PUBLIC CERTIFICATION

I hereby verify that the person shown in the photograph affixed on this page is the same person:

- Whose name appears as the Applicant.
- Whose identity has been proven to my satisfaction through presentation of the identification indicated.
- Whose signature on this document was signed in my presence.

\_\_\_\_\_ Date

\_\_\_\_\_ Notary signature

Notary name \_\_\_\_\_

Address \_\_\_\_\_

Tel \_\_\_\_\_

**SEAL**

**APPLICATION FOR REINSTATEMENT****LESS THAN 6 YEARS IN NON-PRACTISING OR FORMER PHARMACIST REGISTER****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 REINSTATEMENT

## LESS THAN 6 YEARS IN NON-PRACTISING OR FORMER PHARMACIST REGISTER

### 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