Board Meeting Minutes Via Teleconference

February 1, 2013

Present:

Doug Kipp, Chair, District 4 Board Member Beverley Harris, Vice-Chair, District 2 Board Member Robert Craigue, District 5 Board Member Jerry Casanova, District 7 Board Member Kris Gustavson, Board Member Ryan Hoag, Board Member Jeff Slater, Board Member Jeremy Walden, Board Member

Regrets:

Agnes Fridl Poljak, District 1 Board Member Blair Tymchuk, District 3 Board Member Anar Dossa, District 6 Board Member Bal Dhillon, District 8 Board Member

Staff:

Bob Nakagawa, Registrar Lori Tanaka, Executive Assistant to the Deputy Registrar Pina Naccarato, Executive Assistant to the Registrar (Minute Taker)

1. WELCOME AND CALL TO ORDER

Meeting convened at 1:00 pm.

• The Chair turned the meeting over to the Registrar to present the proposed bylaw changes as identified in the pre-circulated documents.

2. RESCIND 2 RESOLUTIONS, INCLUDING THEIR RELEVANT SCHEDULES, FROM THE MEETING OF JANUARY 24, 2013

It was moved (R. Craigue), seconded (B. Harris) that the following resolutions be rescinded:

- a) in accordance with the authority established in section 19(1) of the Health Professions Act, and subject to filing with the Minister as required by section 19(3) of the Health Professions Act, the board amend the bylaws of the College of Pharmacists of British Columbia, as set out in the schedule attached to this resolution. (Below, Resolution A)
- b) in accordance with the authority established in section 21(1) of the Pharmacy Operations and Drug Scheduling Act, and subject to filing with the Minister as required by section 21(4) of the Pharmacy Operations and Drug Scheduling Act, the board amend the bylaws of the College of Pharmacists of British Columbia, as set out in the schedule attached to this resolution. (Below, Resolution B)

The motion was CARRIED

Board Meeting MinutesVia Teleconference

February 1, 2013

Resolution A SCHEDULE

The bylaws of the College of Pharmacists of British Columbia made under the authority of the *Health Professions Act* are amended by repealing Forms 4, 6, 7, 8, 10, 11 and 13, and Schedule D and substituting the attached new Forms 4, 6, 7, 8, 10, 11 and 13 and Schedule D.

Resolution B SCHEDULE

The bylaws of the College of Pharmacists of British Columbia made under the authority of the *Pharmacy Operations and Drug Scheduling Act* are amended by repealing Forms 1 through 6 and Schedule A and substituting the attached new Forms 1 through 6 and Schedule A.

3. BYLAW FORMS FOR FILING WITH THE MINISTER OF HEALTH

DISCUSSION POINTS:

 The Registrar presented the following resolutions to have the HST replaced with the GST on the College forms.

It was moved (J. Slater), seconded (B. Harris) that the following resolution be approved:

a) in accordance with the authority established in section 19(1) of the *Health Professions Act*, and subject to filing with the Minister as required by section 19(3) of the *Health Professions Act*, the board amend the bylaws of the College of Pharmacists of British Columbia, as set out in the schedule attached to this resolution.

The motion was CARRIED

It was moved (R. Craigue), seconded (J. Slater) that the following resolution be approved:

b) in accordance with the authority established in section 21(1) of the Pharmacy Operations and Drug Scheduling Act, and subject to filing with the Minister as required by section 21(4) of the Pharmacy Operations and Drug Scheduling Act, the board amend the bylaws of the College of Pharmacists of British Columbia, as set out in the schedule attached to this resolution.

The motion was CARRIED

3. ADJOURNMENT

The Board Meeting adjourned at 1:05 pm.



Page 1 of 3



FULL PHARMACIST REGISTRATION

APPLICATION FOR

| | | APPLICANT INFORMA | TION |
|------------|--|----------------------------------|--|
| | ☐ Ms ☐ Mrs ☐ Miss | ☐ Mr ☐ Dr | |
| Name | Last name (Surname) | First name | Other name(s) |
| Address | | | Tel (home) |
| | | | Tel (work) |
| | | | Email |
| | City | Province | |
| | Postal code | Country | _ |
| | | | |
| | | PAYMENT OPTION | |
| □ Che | eque/Money order (<i>payable to Colle</i> | ege of Pharmacists of BC) | |
| | | | |
| | SA 🗆 MasterCard | | Registration fee 682.50 |
| Card # | | Exp | |
| Cardholde | er name | | Total <u>\$716.63</u> |
| Cardholde | er signature | | GST # R106953920 |
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| | | | harmacy Operations and Drug Scheduling Act, the of British Columbia made pursuant to these Acts. |
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| I have pro | ofessional liability insurance that m | neets the following criteria | (please check the box(es) below): |
| | Provides a minimum of \$2 million cover | rage. | |
| | Provides occurrence based coverage or | claims made with extended repo | orting period of at least 3 years. |
| | If not in the pharmacist's name, the gr | oup policy covers the pharmacist | as an individual. |
| I have sig | ned and attached <i>(please check t</i> | he box(es) below): | |
| | Statutory Declaration (use form on page | | |
| | Pharmacists Confidentiality Undertaking | g (use form on page 3). | |
| | | | |
| | | | |
| | | | |
| | Date | | Applicant signature |



APPLICATION FOR

FULL 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. |
| | Γ | 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 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 de | clare | e the facts set out herein to be true. |
| | _ | Date Applicant signature |



Page 3 of 3

APPLICATION FOR FULL PHARMACIST REGISTRATION

Pharmacist Confidentiality Undertaking

| _ | to access the PharmaNet clinical and patient database through the in-pharmacy computer system, or owing terms and conditions: |
|---|--|
| | I will not access or use any clinical or patient information in the PharmaNet database or the in- Pharmacy computer system for any purpose other than those authorized by the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act and the Bylaws of the College of Pharmacists of BC made pursuant to these Acts. |
| | I agree at all times to treat as confidential all information referred to in paragraph (1) and will not participate in or permit, the unauthorized release, publication or disclosure of the said information to any person, corporation or other entity under any circumstances except as authorized by the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act and the Bylaws of the College of Pharmacists of BC made pursuant to these Acts. |
| | I agree at all times, to treat as confidential all information relating to the security and management of the PharmaNet database and the in-pharmacy computer system. |
| | I agree to be bound by the provisions of this agreement and will continue to do so following termination of employment in the pharmacy for any reason. |
| | I agree to adhere to all policies and procedures issued by the pharmacy manager and/or the pharmacy owner, consistent with legislation, policies, procedures and standards issued by the College of Pharmacists of British Columbia or the Province of British Columbia, related to the confidentiality, privacy and security of the patient or clinical information contained in the PharmaNet database and the in-pharmacy computer database. |
| | Date Applicant signature |

Note:

- 1. Attach original with application for registration.
- 2. Make a copy for the pharmacy manager to be retained in the pharmacy files.



Page 1 of 3



APPLICATION FORLIMITED PHARMACIST REGISTRATION

| | | APPLICANT INFORMATI | ION |
|-------------|---------------------------------------|---------------------------------------|--|
| | ☐ Ms ☐ Mrs ☐ Mis | ss 🗆 Mr 🗆 Dr | |
| Name | Last name (Surname) | First name | Other name(s) |
| Address | , , | THISCHAINC | Tel (home) |
| 7 taar CSS | | | , , |
| | | | Tel (work) |
| | City | Province | Email |
| | Postal code | Country | |
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| | | PAYMENT OPTION | |
| | | | |
| ☐ Chec | que/Money order (payable to Col | llege of Pharmacists of BC) | |
| □ VISA | A ☐ MasterCard | | Registration fee 682.50 |
| Card # _ | | Exp | / GST <u>34.13</u> |
| Cardholder | r name | | Total <u>\$716.63</u> |
| | | | GST # R106953920 |
| Cardholder | signature | | |
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| | | | rmacy Operations and Drug Scheduling Act, the British Columbia made pursuant to these Acts. |
| PHATHIACISC | s Regulation and the bylaws of | the College of Pharmacists of | British Columbia made pursuant to these Acts. |
| I have prof | essional liability insurance that | meets the following criteria: | |
| | Provides a minimum of \$2 million cov | | |
| | Provides occurrence based coverage | or claims made with extended reporti | ing period of at least 3 years. |
| | If not in the pharmacists' name, the | group policy covers the pharmacist as | s an individual. |
| I have sign | ed and attached: | | |
| | Statutory Declaration (use form on) | nage 2) | |
| | , | , - , | |
| Ц | Pharmacists Confidentiality Undertak | ang (use rorm on page s). | |
| | | | |

Applicant signature

Date



APPLICATION FOR

LIMITED 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 ded | clare | e the facts set out herein to be true. |
| | _ | Date Applicant signature |



Page 3 of 3

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APPLICATION FORLIMITED PHARMACIST REGISTRATION

Pharmacist Confidentiality Undertaking

| _ | to access the PharmaNet clinical and patient database through the in-pharmacy computer system, or owing terms and conditions: |
|---|--|
| | I will not access or use any clinical or patient information in the PharmaNet database or the in- Pharmacy computer system for any purpose other than those authorized by the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act and the Bylaws of the College of Pharmacists of BC made pursuant to these Acts. |
| | I agree at all times to treat as confidential all information referred to in paragraph (1) and will not participate in or permit, the unauthorized release, publication or disclosure of the said information to any person, corporation or other entity under any circumstances except as authorized by the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act and the Bylaws of the College of Pharmacists of BC made pursuant to these Acts. |
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| | I agree to adhere to all policies and procedures issued by the pharmacy manager and/or the pharmacy owner, consistent with legislation, policies, procedures and standards issued by the College of Pharmacists of British Columbia or the Province of British Columbia, related to the confidentiality, privacy and security of the patient or clinical information contained in the PharmaNet database and the in-pharmacy computer database. |
| | Date Applicant signature |
| | |

Note:

- 1. Attach original with application for registration.
- 2. Make a copy for the pharmacy manager to be retained in the pharmacy files.



CANADA - AGREEMENT ON INTERNAL TRADE (AIT)

CHECKLIST

You must submit

| 1. | | Checklist (page 1). |
|-----|-----|---|
| 2. | | Application form (page 2). |
| 3. | | Copy of birth certificate or Canadian citizenship card. |
| 4. | | Copy of university degree(s). |
| 5. | | Letter of current standing to be mailed to College office directly from applicant's existing regulatory authorities. Letter must be dated within three months prior to the date of the application. |
| 6. | | Notarized identification (use form on page 3). |
| 7. | | Declaration of currency with legislation and practice standards (use form on page 4). |
| 8. | | Statutory declaration (use form on page 5). |
| 9. | | Criminal record check authorization (use form on page 6). |
| Yo | u m | nust submit IF |
| 10. | | Copy of PEBC certification - if applicable. |
| 11. | | Copy of name change or marriage certificate - if name on any document is different from legal name. |
| 12. | | 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. |
| 13. | | A letter/certificate of standing from each regulatory body - if you have engaged in the practice of pharmacy or another health profession in a Canadian or foreign 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.





CANADA - AGREEMENT ON INTERNAL TRADE (AIT)

Application Form

| | | CO | NTACT INFO | RMATION | | |
|--------------|------------------------------|--------------------------|------------------|------------------------|-------------------|---------------------|
| | □ Ms □ Mrs | □ Miss □ Mr | □ Dr | | | |
| Legal name | Last name (Surname) | Ein | st name | Other name(s) | | |
| Address | Last Harrie (Surname) | rns | st name | | (home) | |
| | | | | | | |
| | | | | Ema | | |
| | City | Pro | ovince | | | |
| | Postal code | Соц | ıntry | | | |
| | | | | | | |
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| | | 01 | THER INFOR | MATION | | |
| 1) Education | On University/Country | | | | | |
| i) Ladeack | , | | | | ^ | |
| 2) Birth da | | | | | | ES NO |
| | | | | | | |
| 3) Is this t | he first time you have | applied for pre-regi | istration with t | he College of Pharmaci | sts of BC? | |
| | | | | | | |
| | | | | | | |
| | | | PAYMENT OF | PTION | | |
| ☐ Chec | que/Money order <i>(paya</i> | ble to College of Pharma | acists of BC) | | | |
| □ VISA | A □ Master | Card | | | Application fee * | 335.00 |
| Card # | | | | Exp/ | GST | 16.75 |
| Cardhold | | | | r | Total | <u>\$351.75</u> |
| | ler signature | | | | | GST # R106953920 |
| Carunoid | er signature | | | | * Includes cn | iminal record check |
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| | | | | | | |
| | | | | | | |
| | Date | | | Applic | ant signature | |



CANADA - AGREEMENT ON INTERNAL TRADE (AIT)

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 of from legal name. | n any document is different |
| - | Photo |
| Required identification - one primary and one s | econdary. |
| Identification presented to the Notary Public must be the issued by the government agency. Photocopies are acc | _ |
| by the issuing government agency to be true copies of | |
| | |
| PRIMARY | SECONDARY |
| Document type Document number | Document type Document number |
| ☐ Birth certificate | Passport |
| ☐ Canadian citizen card | □ Valid Canadian driver's license |
| ☐ Canadian identity card | British Columbia identification card |
| | Naturalization certificate |
| | Canadian Forces identification |
| Date | Applicant signature |
| NOTARY PUBLI | C CERTIFICATION |
| I hereby verify that the person shown in the photograph aff Whose name appears as the Applicant. Whose identity has been proven to my satisfaction Whose signature on this document was signed in | n through presentation of the identification indicated. |
| Date | Notary signature |
| N. | otary name |
| SEAL | Address |
| | |
| | Tol |
| | Tel |







CANADA - AGREEMENT ON INTERNAL TRADE (AIT)

Declaration of Currency with Legislation and Practice Standards

DECLARATION ___, confirm my knowledge of: The legislation defined in: The Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Regulation and Bylaws of the College of Pharmacists of BC made pursuant to these Acts, The College of Pharmacists of BC Professional Practice Policies, The Food & Drugs Act and Regulations, and The Controlled Drugs & Substances Act. The practice standards defined in the Framework of Professional Practice. Applicant signature



CANADA - AGREEMENT ON INTERNAL TRADE (AIT)

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 ded | clare | e the facts set out herein to be true. |
| | _ | Date Applicant signature |



CANADA - AGREEMENT ON INTERNAL TRADE (AIT)

Criminal Record Check Authorization

| | | | APPLICANT INFORMATIO | N | |
|-------|--------------------------------|---|--|--|-----------------|
| Lega | al name | | | | |
| Mail | ing address | Last name (Surname) | First name | Other name(s) | |
| | | Street | City/town | Province/State | Postal Code |
| | | Country | Contact phor | Area code | |
| Gen | der | □ Male □ Female E | 3.C. Driver License | | |
| Birth | n date | | Birthplace | | |
| Othe | er names used | YYYY-MM-DD d or have used (e.g. maiden na | City/town nme, birth name, previous married name) | Province/State | Country |
| | | () 3 | , | | |
| | 1. | Surname | First name | Middle name | |
| | 2. | Surname | First name | Middle name | |
| | 3. | Surname | First name | Middle game | |
| | | Surraine | Tilst halile | Mudicularite | |
| | | FREEDOM OF INFO | RMATION AND PROTECTION O | F PRIVACY ACT (FOIPPA) | |
| The i | nformation req | uested on this form is collected | under the authority of the Criminal Reco | rds Review Act and in the case of child care | facilities, the |
| | | | hich govern both these acts. The informa criminal records information and is in con | ation provided will be used to fulfill the requi | rements of |
| | | | | | |
| | | CONSENT FOR RE | LEASE OF INFORMATION AND | ACKNOWLEDGEMENTS | |
| | | Pursua | nt to the B.C. Criminal Records | s Review Act | |
| • | | | | r I have a conviction or outstanding charge | e for |
| • | I hereby auth | | | y of the police, the court and crown counsel | relating to |
| • | Where the re | | a criminal record or outstanding charge | e for a relevant offence may exist, I agree t | o provide |
| • | The Deputy R | | organization that I have an outstanding | charge or conviction for any relevant offer | ice(s) and |
| • | | | or not I present a risk to physical or sex | ual abuse to children. | |
| • | The Deputy R I have receive | | disclosed to my organization and it will i | nclude consideration of any relevant offence | for which |
| • | agree to repo | | , . | criminal record check authorized herein, I folion, in a timely manner, with a new-signed $\boldsymbol{\theta}$ | |
| | "Deputy Registi | rar" means a person appointed under | the Public Service Act as deputy registrar for th | ne purposes of this Act. | |
| | | | | | |
| | | and understood the Conser as indicated by my signatu | | cknowledgements above. I hereby con | sent to |
| | | | nacists of British Columbia to conduct at I may withdraw this consent for fo | ct criminal record checks on an ongoin uture criminal record checks. | ıg |
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| | | | | | |
| | | | | | |

Applicant signature



CANADA - NON AGREEMENT ON INTERNAL TRADE (NON AIT)

CHECKLIST

You must submit

| 1. | Ш | Checklist (page 1). |
|-----|-----|---|
| 2. | | Application form (page 2). |
| 3. | | Copy of birth certificate or Canadian citizenship card. |
| 4. | | Copy of university degree(s). |
| 5. | | Letter of current standing to be mailed to College office directly from applicant's existing regulatory authorities. Letter must be dated within one month prior to the date of the application. |
| 6. | | Notarized identification (use form on page 3). |
| 7. | | Certification of Pharmacy Related Employment (use form on page 4). |
| 8. | | Statutory declaration (use form on page 5). |
| 9. | | Criminal record check authorization (use form on page 6). |
| You | u m | nust submit IF |
| 10. | | Copy of name change or marriage certificate - if name on any document is different from legal name. |
| 11. | | Copy of PEBC certification – if applicable. |
| 12. | | 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. |
| 13. | | A letter/certificate of standing from each regulatory body - if you have engaged in the practice of pharmacy or another health profession in a Canadian or foreign 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.



CANADA - NON AGREEMENT ON INTERNAL TRADE (NON AIT)

Application Form

| | | CONTA | CT INFORMATION | ı | |
|--------------|------------------------------|--------------------------|------------------------|-----------------------|----------------------------|
| Legal name | □ Ms □ Mrs | □ Miss □ Mr | □ Dr | | |
| Legal Hame | Last name (Surname) | First nan | ne | Other name(s) | |
| Address | | | | Tel (home) | |
| | | | | Tel (work) | |
| | | | | Email | |
| | City | Province | | | |
| | Postal code | Country | | | |
| | | | | | |
| | | | | | |
| | | OTHE | R INFORMATION | | |
| 4) Educatio | | | | | |
| 1) Education | on <i>University/Country</i> | | | | |
| | Degree/Year | | | | |
| 2) Birth da | te <i>YYYY-MM -DD</i> | | — | | YES NO |
| 3) Is this t | he first time you have | applied for pre-registre | ition with the College | of Pharmacists of BC? | |
| | | | | | |
| | | | | | |
| | | PA | MENT OPTION | | |
| ☐ Chec | que/Money order <i>(paya</i> | Mark Cillana of Diamond | -6.RC) | | |
| | | | or BC) | Application f | ee * 335.00 |
| □ VISA | A ☐ Master | Card | • | GST | 16.75 |
| Card # | | | Exp | / Total | \$351.75 |
| Cardhold | er name | | | | CCT # D10C0F3030 |
| Cardhold | er signature | | | | GST # R106953920 |
| | | | | * Incl | udes criminal record check |
| | | | | | |
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| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | Date | | | Applicant signature | |



CANADA - NON AGREEMENT ON INTERNAL TRADE (NON AIT)

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 o | |
| from legal name. | |
| Required identification - one primary and one se | econdary. Photo |
| Identification presented to the Notary Public must be the issued by the government agency. Photocopies are accept by the issuing government agency to be true copies of | ne original document eptable only if certified |
| PRIMARY Document type Document number | SECONDARY Document type Document number |
| □ Birth certificate | Passport |
| ☐ Canadian citizen card | Valid Canadian driver's license |
| ☐ Canadian identity card | British Columbia identification card |
| | □ Naturalization certificate |
| | ☐ Canadian Forces identification |
| Date | Applicant signature |
| NOTABY BURLE | C CERTIFICATION |
| I hereby verify that the person shown in the photograph affi Whose name appears as the Applicant. | xed on this page is the same person: n through presentation of the identification indicated. |
| Date | Notary signature |
| No | otary name |
| | |
| SEAL | Address |
| | |
| | Tel |







CANADA - NON AGREEMENT ON INTERNAL TRADE (NON AIT)

Certification of Pharmacy Related Employment

| | EMPLOYMENT INFORMATION |
|---|---|
| | |
| Applicant name | |
| Applicant name | |
| Faralasias nama | |
| Employer name | |
| Address | |
| | |
| | |
| Tel | Fax |
| | |
| Position | Total hours worked |
| | |
| Start date | End date |
| | |
| | |
| | |
| | EMPLOYER CERTIFICATION |
| | |
| I certify that the above employment infor | rmation is correct. |
| | |
| Name | |
| Position | |
| Pharr | macy Manager / Pharmacy Owner / Human Resources Manager |
| | |
| | |
| | |
| | |
| Date | Employer signature |

Page 5 of 6

CANADA - NON AGREEMENT ON INTERNAL TRADE (NON AIT)

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 | 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 | 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 | 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 | 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 | 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 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 d | ecla | are | the facts set out herein to be true. |
| | | | Date Applicant signature |



CANADA - NON AGREEMENT ON INTERNAL TRADE (NON AIT)

Criminal Record Check Authorization

| | | | APPLICANT INFORMATION | | |
|-----------------|--|--|--|--|---|
| | | | | | |
| | al name | Last name (Surname) | First name | Other name(s) | |
| Mailing address | | Street | City/town | Province/State | Postal Code |
| | | Country | Contact phone _ | Area code | |
| Gend | der | □ Male □ Female E | 3.C. Driver License | | |
| Rirth | n date | F | Birthplace | | |
| | | YYYY-MM-DD | City/town | Province/State | Country |
| Othe | er names use | d or have used <i>(e.g. maiden na</i> | ame, birth name, previous married name) | | |
| | 1. | Surname | First name | Middle name | |
| | 2. | Surname | First name | Middle name | |
| | 3. | Surname | First name | Middle verme | |
| | | Sumame | Trist fiame | Middle Maine | |
| | | FREEDOM OF INFO | RMATION AND PROTECTION OF PR | RIVACY ACT (FOIPPA) | |
| Comr | I hereby con any relevant I hereby autian outstandin Where the remy fingerprir The Deputy Fithe matter has the Deputy Fithe Deputy Fithe Deputy Fithe Matter Fithe Matter Fithe Deputy Fithe Matter Fither Fit | collity Act, and the regulations was Review Act for the release of CONSENT FOR RE Pursual sent to a check for records of coffences under the Criminal Rechorize the release to the Deputing charge or conviction of any results of this check indicate that its to verify any such criminal receptions. Registrar will notify me and my as been referred to the Deputy Registrar will determine whether Registrar's determination will be | Registrar any documents in the custody of televant offence as defined under the Criminal I a criminal record or outstanding charge for accord. Organization that I have an outstanding charge for accord. | provided will be used to fulfill the rence with the FOIPPA. KNOWLEDGEMENTS Eview Act ave a conviction or outstanding characteristic country and crown country are police, the court and crown country are relevant offence may exist, I agree a relevant offence may exist, I agree or conviction for any relevant of the buse to children. | arge for nsel relating to ee to provide ffence(s) and |
| • | If I am charg | ed with or convicted of a releva | nt offence at any time subsequent to the criming organization and provide my organization, i | | |
| | "Deputy Regist | trar" means a person appointed under | the Public Service Act as deputy registrar for the pur | poses of this Act. | |
| | | | | | |
| | these terms I hereby au | s as indicated by my signatu thorize the College of Pharn | nt for Release of Information and Acknoure below. nacists of British Columbia to conduct cr at I may withdraw this consent for future | iminal record checks on an onc | |
| | | | | | |

Applicant signature



CANADA - NEW GRADUATE

CHECKLIST

You must submit

| 1. | Ш | Checklist (page 1). |
|-----|------|--|
| 2. | | Application form (page 2). |
| 3. | | Copy of birth certificate or Canadian citizenship card. |
| 4. | | Copy of university degree(s) or letter from the Dean confirming the date the degree is to be received. |
| 5. | | Proof of registration for PEBC Qualifying Examinations Part I and Part II. |
| 6. | | Notarized identification (use form on page 3). |
| 7. | | Statutory declaration (use form on page 4). |
| 8. | | Criminal record check authorization (use form on page 5). |
| Y | ou r | nust submit IF |
| 9. | | Copy of name change or marriage certificate - if name on any document is different from legal name. |
| 10. | | 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. |
| 11. | | 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 |

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.

and must be mailed to the college office directly from the regulatory bodies.



CANADA - NEW GRADUATE

Application Form

| | | | CONTACT INFO | RMATION | | |
|--------------|------------------------|-------------------|-----------------------|------------------------|-----------------------|-----------------|
| | □ Ms □ Mrs | □ Miss | □ Mr □ Dr | | | |
| Legal name | Last name (Surname) | | First name | Other name(s) | | |
| Address | Last Harrie (Surname) | | Thist name | | (home) | |
| | | | | Tel (| (work) | |
| | | | | Ema | | |
| | City | | Province | | | |
| | Postal code | | Country | | | |
| | | | | | | |
| | | | | | | |
| | | | OTHER INFOR | MATION | | |
| | | | | | | |
| 1) Education | on University/Country | | | | | |
| | Degree/Year | | | \rightarrow | | |
| 2) Birth da | ite YYYY-MM -DD | | | | YES | NO |
| 3) Is this t | he first time you have | applied for pre | e-registration with t | he College of Pharmaci | sts of BC? | |
| | | | | | | |
| | | | | | | |
| | | | PAYMENT O | PTION | | |
| | | | | | | |
| ☐ Che | que/Money order (p | ayable to College | of Pharmacists of BC) | | | |
| □ VISA | A 🗆 Master | Card | • | | Application fee * GST | 335.00 16.75 |
| Card #_ | | | | Exp/ | Total | \$351.75 |
| Cardhold | ler name | 7 Y | | | GS | T # R106953920 |
| Cardhold | ler signature | | | | | |
| | | | | | * Includes crimina | al record check |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | Date | | | Applic | ant signature | |



CANADA - NEW GRADUATE

Notarized Identification

| | APPLICANT IN | FORMATION | |
|--|--------------------------------|--|-----------------|
| Applicant name | | | |
| | | | |
| Required Documents | | | |
| Passport photograph, taken wi | | | |
| Copy of name change or marri from legal name. | iage certificate if name on ar | ny document is different | |
| Required identification - one | e primary and one seco | ondary. | Photo |
| Identification presented to the issued by the government age by the issuing government age | ncy. Photocopies are accepta | able only if certified | |
| PRIMAI | RY | SECONDARY | |
| Document type | Document number | Document type | Document number |
| ☐ Birth certificate | 9 | Passport | |
| ☐ Canadian citizen card | (6 | Valid Canadian driver's license | |
| ☐ Canadian identity card | | British Columbia identification card | |
| | Q | Naturalization certificate | |
| | | Canadian Forces identification | |
| Date | NOTARY PUBLIC O | Applicant signat | ure |
| | | | |
| | the Applicant. | rough presentation of the identification | on indicated. |
| Date | | Notary signatu | re |
| | Notary | y name | |
| | | | |
| SEAL | A | Address | |
| | | | |
| | | Tel | |

Page 4 of 5



APPLICATION FOR PRE-REGISTRATION

CANADA - NEW GRADUATE

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 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 ded | clare | e the facts set out herein to be true. |
| | _ | Date Applicant signature |



CANADA - NEW GRADUATE

Criminal Record Check Authorization

| | | APPLICANT INFORMATION | | |
|----------------|--|--|--|---------------------------------------|
| Legal name | | | | |
| | Last name (Surname) | First name | Other name(s) | · · · · · · · · · · · · · · · · · · · |
| Mailing addr | ess Street | City/town | Province/State | Postal Code |
| | Country | Contact phone | Area code | |
| Gender | □ Male □ Female | B.C. Driver License | | |
| Birth date | | Birthplace | | |
| Other names | YYYY-MM-DD | City/town name, birth name, previous married name) | Province/State | Country |
| Other hames | | iame, birtir name, previous marneu name) | | |
| | 1. Surname | First name | Middle name | |
| | 2. Surname | First name | Middle name | ···· |
| | 3. Surname | First name | Middle pame | |
| | camame | The name | - Andrews | |
| | FREEDOM OF INFO | RMATION AND PROTECTION OF | PRIVACY ACT (FOIPPA) | |
| | | d under the authority of the Criminal Records | | |
| the Criminal R | ecords Review Act for the release o | which govern both these acts. The information of criminal records information and is in comp | liance with the FOIPPA. | nents or |
| | CONSENT FOR R | ELEASE OF INFORMATION AND A | CKNOWLEDGEMENTS | |
| | | ant to the B.C. Criminal Records | | |
| T bb- | | | | |
| | evant offences under the Criminal Re | criminal convictions to determine whether I ecords Review Act. | nave a conviction or outstanding charge fo | or |
| | | ty Registrar any documents in the custody o relevant offence as defined under the Crimina | | lating to |
| | the results of this check indicate the erprints to verify any such criminal | at a criminal record or outstanding charge for | or a relevant offence may exist, I agree to p | provide |
| The Dep | outy Registrar will notify me and m | y organization that I have an outstanding ch | narge or conviction for any relevant offence | (s) and |
| | ter has been referred to the Deputy outy Registrar will determine whether | Registrar. er or not I present a risk to physical or sexual | l abuse to children. | |
| | outy Registrar's determination will beceived a pardon. | e disclosed to my organization and it will incl | lude consideration of any relevant offence fo | r which |
| • If I am | charged with or convicted of a relev | ant offence at any time subsequent to the cri | The state of the s | |
| | report the charge or conviction to nal Record Check form. | my organization and provide my organization | n, in a timely manner, with a new-signed Cor | sent to |
| "Deputy | Registrar" means a person appointed und | er the Public Service Act as deputy registrar for the p | ourposes of this Act. | |
| | | | | |
| | read and understood the Conse erms as indicated by my signat | ent for Release of Information and Ackr ture below. | nowledgements above. I hereby conser | nt to |
| | | macists of British Columbia to conduct may withdraw this consent for future cr | | basis |
| | | | | |
| | | | | |
| | | | | |

Applicant signature



USA

CHECKLIST

You must submit

| 1. | | Checklist (page 1). | |
|--------------------|--|--|--|
| 2. | | Application form (page 2). | |
| 3. | | Copy of birth certificate or Canadian citizenship card. | |
| 4. | | Copy of university degree(s). | |
| 5. | | Letter of current standing to be mailed to College office directly from applicant's existing regulatory authorities. Letter must be dated within one month prior to the date of the application. | |
| 6. | | Notarized identification (use form on page 3). | |
| 7. | | Certification of Pharmacy Related Employment (use form on page 4). | |
| 8. | | Statutory declaration (use form on page 5). | |
| 9. | | Criminal record check authorization (use form on page 6). | |
| You must submit IF | | | |

| 10. | П | from legal name. |
|-----|---|--|
| 11. | | 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. |
| 12. | | A letter /certificate of standing from each regulatory body - if you have engaged in the practice of pharmacy or another health profession in a Canadian or foreign 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.



USA

Application Form

| | | CONTA | CT INFORMATION | | |
|--------------|------------------------|--------------------------------|--------------------------|-----------------------|-----------------------------|
| Legal name | □ Ms □ Mrs | □ Miss □ Mr | □ Dr | | |
| Legal Hame | Last name (Surname) | First nam | ne | Other name(s) | |
| Address | | | | Tel (home) | |
| | | | | Tel (work) | |
| | | | | Email | |
| | City | Province | | | |
| | Postal code | Country | | | |
| | | | | | |
| | | | | | |
| | | OTHE | R INFORMATION | | |
| 1) Education | 27 44 11 11 16 4 | | | | |
| 1) Education | | | | | |
| | Degree/Year | · | | | |
| 2) Birth da | te YYYY-MM -DD | | ~) | | YES NO |
| 3) Is this t | he first time you have | applied for pre-registra | tion with the College of | of Pharmacists of BC? | |
| | | | | | |
| | | | | | |
| | | PAY | MENT OPTION | | |
| По | (NA | | | | |
| | | able to College of Pharmacists | of BC) | Application 1 | fee * 335.00 |
| □ VISA | A □ Master | Card | • | GST | 16.75 |
| Card # | | | Exp | | \$351.75 |
| Cardhold | er name | | | | |
| Cardhold | er signature | | | | GST # R106953920 |
| | | | | * Inc | ludes criminal record check |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | Date | - | | Applicant signature | |



USA

Notarized Identification

| APPLICANI | INFORMATION |
|--|---|
| Applicant name | |
| | |
| Required Documents | |
| Passport photograph, taken within one year, affixed to | |
| Copy of name change or marriage certificate if name of from legal name. | on any document is different |
| Required identification - one primary and one s | secondary. Photo |
| Identification presented to the Notary Public must be to issued by the government agency. Photocopies are acceptable in the inclusion of the property of the inclusion of the property of the inclusion of the inc | ceptable only if certified |
| by the issuing government agency to be true copies of | the original. |
| PRIMARY Document type Document number | SECONDARY Document type Document number |
| ☐ Birth certificate | ☐ Passport |
| ☐ Canadian citizen card | □ Valid Canadian driver's license |
| ☐ Canadian identity card | British Columbia identification card |
| | □ Naturalization certificate |
| | ☐ Canadian Forces identification |
| Date | Applicant signature |
| NOTARY PUBL | IC CERTIFICATION |
| I hereby verify that the person shown in the photograph aff | fixed on this page is the same person: on through presentation of the identification indicated. |
| Date | Notary signature |
| N | lotary name |
| | , |
| SEAL | Address |
| | Tel |







USA

Certification of Pharmacy Related Employment

| | EMPLOYMENT INFORMATION |
|---------------------------|--|
| | |
| A P | |
| Applicant name | |
| | |
| Employer name | |
| Address | |
| | |
| | |
| | |
| Tel | Fax |
| | |
| Position | Total hours worked |
| Start date | End date |
| Start date | End date |
| | |
| | |
| | EMPLOYER CERTIFICATION |
| | EMPLOYER CERTIFICATION |
| I certify that th | |
| I certify that th | EMPLOYER CERTIFICATION e above employment information is correct. |
| | |
| I certify that th Name | |
| | e above employment information is correct. |
| Name | |
| Name | e above employment information is correct. |
| Name | e above employment information is correct. |
| Name | e above employment information is correct. |



USA

Page 5 of 6

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. |
| | | | |
| | | | |
| Ι | dec | lare | the facts set out herein to be true. |
| | | | Date Applicant signature |



USA

Criminal Record Check Authorization

| | | | APPLICANT INFORMATION | | |
|-----------------|----------------------------------|--|---|---|--------------------------------------|
| | | | | | |
| Leg | al name | Last name (Surname) | First name | Other name(s) | |
| Mailing address | | Street | City/town | Province/State | Postal Code |
| | | Country | Contact phone | Area code | |
| Gen | dor | , | .C. Driver License | 7.1. ca coac | |
| Gen | uei | □ Indie □ Feilidie □ | .c. Driver License | | |
| Birtl | n date | B | irthplace | Prevince/State | Country |
| Oth | er names use | d or have used (e.g. maiden na | me, birth name, previous married name) | | |
| | 1. | Surname | First name | Middle name | |
| | 2. | Surname | First name | Middle name | |
| | 2 | Surname | First name | Middle name | |
| | 3. | Surname | First name | Middle pame | |
| | | EREEDOM OF INFOR | MATION AND PROTECTION OF P | DELVACY ACT (FOIDDA) | |
| | | | | | |
| The i | nformation red munity Care Fa | quested on this form is collected acility Act, and the regulations w | under the authority of the Criminal Records hich govern both these acts. The information | Review Act and in the case of child on provided will be used to fulfill the r | care facilities, the requirements of |
| the C | Criminal Record | ds Review Act for the release of c | criminal records information and is in complia | ance with the FOIPPA. | |
| | | CONSENT FOR REI | LEASE OF INFORMATION AND AC | CKNOWLEDGEMENTS | |
| | | Pursuai | nt to the B.C. <i>Criminal Records R</i> | eview Act | |
| | I hereby con- | sent to a check for records of c | riminal convictions to determine whether I | have a conviction or outstanding ch | arge for |
| • | any relevant | offences under the Criminal Reco | ords Review Act. | - | |
| • | | | Registrar any documents in the custody of levant offence as defined under the Criminal | | insel relating to |
| • | | sults of this check indicate that ats to verify any such criminal red | a criminal record or outstanding charge for ord. | a relevant offence may exist, I agr | ree to provide |
| • | The Deputy F | Registrar will notify me and my | organization that I have an outstanding cha | arge or conviction for any relevant o | offence(s) and |
| • | | as been referred to the Deputy R Registrar will determine whether | egistrar. or not I present a risk to physical or sexual a | abuse to children. | |
| • | The Deputy F | | disclosed to my organization and it will inclu | de consideration of any relevant off | ence for which |
| • | | , | at offence at any time subsequent to the crin | ninal record check authorized herein | , I further |
| | | ort the charge or conviction to mecord Check form. | y organization and provide my organization, | in a timely manner, with a new-sigr | ned Consent to |
| | "Deputy Regist | trar" means a person appointed under | the Public Service Act as deputy registrar for the pu | rposes of this Act. | |
| | | | | | |
| | | | | | |
| | I have read these terms | l and understood the Consen s as indicated by my signatu | it for Release of Information and Acknore below. | owledgements above. I hereby | consent to |
| | I hereby aut | thorize the College of Pharm | acists of British Columbia to conduct of I may withdraw this consent for future | riminal record checks on an one | going |
| | | , ca.c anderotand the | ind consent for fatal | | |
| | | | | | |
| | | | | | |

Applicant signature

Date





USA - NEW GRADUATE

CHECKLIST

You must submit

| 1. | | Checklist (page 1). |
|-----|------|---|
| 2. | | Application form (page 2). |
| 3. | | Copy of birth certificate or Canadian citizenship card. |
| 4. | | Copy of university degree(s) or letter from the Dean confirming the date the degree is to be received. |
| 5. | | Proof of registration for PEBC Qualifying Examinations Part I and Part II. |
| 6. | | Notarized identification (use form on page 3). |
| 7. | | Statutory declaration (use form on page 4). |
| 8. | | Criminal record check authorization (use form on page 5). |
| Y | ou n | nust submit IF |
| 9. | | Copy of name change or marriage certificate - if name on any document is different from legal name. |
| 10. | | 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. |
| 11. | | 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.



USA - NEW GRADUATE

Application Form

| | | CONTACT INFORM | ATION | |
|---------------|--|-------------------------------|--|--|
| | □ Ms □ Mrs □ Miss | □ Mr □ Dr | | |
| Legal nam | Last name (Surname) | First name | Other name(s) Tel (home) | |
| | | | Tel (work) | |
| | | | Email | |
| | City | Province | | |
| | Postal code | Country | | |
| | | OTHER INFORMA | TION | |
| 1) Educ | , , | | | |
| 2) D:-#b | Degree/Year | |) | VEC. NO. |
| • | date YYYY-MM -DDis the first time you have applied f | | | YES NO |
| | | PAYMENT OPT | ION | |
| □ C | hagua/Manay ardar (navablata) | College of Pharmaciera of RC) | | |
| □ V Card : | ISA | college of Pharmacists of BC) | Application to GST Exp/ Total | fee * 335.00 16.75 \$351.75 GST # R106953920 |
| Cardh | older signature | | * Inc | ludes criminal record check |
| | | | | |
| | | | | |
| | | | | |
| - | Date | | Applicant signature | |



USA - NEW GRADUATE

Notarized Identification

| | | APPLICANT | INFORMATI | ON | | | |
|----------------------------|-----------------------|---|-----------------|----------------------------|-----------------------|--|--|
| | | | | | | | |
| Applicant name | | | | | | | |
| Required Docu | ments | | | | | | |
| Passport photo | graph, taken within | one year, affixed to | space provide | d. | | | |
| | | certificate if name of | n any docume | nt is different | | | |
| from legal nam | e. | | | | Dist | | |
| Required identif | fication - one p | rimary and one s | econdary. | | Photo | | |
| | | ary Public must be t | | | | | |
| | | Photocopies are acc to be true copies of | | certified | | | |
| | | | | | | | |
| | | | | | | | |
| Docume | PRIMARY nt type | Document number | | SECONI | Document number | | |
| ☐ Birth certif | | | ☐ Passport | | | | |
| | citizen card | | | adian driver's license | | | |
| ☐ Canadian | identity card | | ☐ British Co | lumbia identification card | | | |
| | | | □ Naturaliza | ation certificate | | | |
| | | | ☐ Canadian | Forces identification | | | |
| | 6 | | | | | | |
| | Date | | | Applicant | signature | | |
| | | NOTARY PUBLI | C CERTIFICA | ATION | | | |
| | | | | | | | |
| I hereby verify that | the person shown i | n the photograph aff | ixed on this pa | ige is the same perso | on: | | |
| Whose na | ame appears as the | Applicant. | | | | | |
| | | ven to my satisfaction | | sentation of the iden | tification indicated. | | |
| ■ Whose sig | gnature on this doc | ument was signed in | my presence. | | | | |
| | | | | | | | |
| | | | | | | | |
| | Date Notary signature | | | | | | |
| | 2 200 | | | , | 9 | | |
| | | N | otary name | | | | |
| CI | EAL | | Address | | | | |
| 31 | | | | | | | |
| | | | | | | | |
| | | | | | | | |



USA - NEW GRADUATE

Page 4 of 5

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 ded | clare | e the facts set out herein to be true. |
| | | |
| | _ | Date Applicant signature |



USA - NEW GRADUATE

Criminal Record Check Authorization

| | | | APPLICANT INFORMATION | | |
|-----------------|-------------------------------|--|--|--|----------------------|
| | | | | | |
| Lega | al name | Last name (Surname) | First name | Other name(s) | |
| Mailing address | | Street | City/town | Province/State | Postal Code |
| | | Country | Contact phone | Area code | |
| Gen | der | ☐ Male ☐ Female B.0 | C. Driver License | | |
| Rirtl | n date | Rir | thplace | | |
| | | YYYY-MM-DD | City/town | Province/State | Country |
| Othe | er names use | d or have used <i>(e.g. maiden nam</i> | e, birth name, previous married name) | | |
| | 1. | Surname | First name | Middle name | |
| | 2. | Surname | First name | Middle name | |
| | 3. | Surname | First name | Middle name | |
| | | Surname | First flame | middle harrie | |
| | | FREEDOM OF INFORM | MATION AND PROTECTION OF | PRIVACY ACT (FOIPPA) | |
| The i | nformation red | quested on this form is collected u | nder the authority of the Criminal Record | ds Review Act and in the case of child | care facilities, the |
| | | | ch govern both these acts. The informat iminal records information and is in comp | | requirements of |
| | | CONSENT FOR PEL | EASE OF INFORMATION AND A | ACKNOWI EDGEMENTS | |
| | | | t to the B.C. Criminal Records | | |
| | | Pursuan | t to the B.C. Criminal Records | Review Act | |
| • | | sent to a check for records of cri offences under the Criminal Recor | minal convictions to determine whether ds Review Act. | I have a conviction or outstanding ch | narge for |
| • | | | Registrar any documents in the custody want offence as defined under the Crimir | | unsel relating to |
| • | | esults of this check indicate that a nts to verify any such criminal reco | criminal record or outstanding charge ford. | for a relevant offence may exist, I ag | ree to provide |
| • | | Registrar will notify me and my or as been referred to the Deputy Re | rganization that I have an outstanding o | charge or conviction for any relevant | offence(s) and |
| • | The Deputy F | Registrar will determine whether o | r not I present a risk to physical or sexua | al abuse to children. | |
| • | The Deputy I I have receiv | | isclosed to my organization and it will in | clude consideration of any relevant of | fence for which |
| • | agree to repo | | offence at any time subsequent to the c organization and provide my organizatio | | • |
| | "Deputy Regis | trar" means a person appointed under th | ne Public Service Act as deputy registrar for the | purposes of this Act. | |
| | | | | | |
| | | | for Release of Information and Ack | knowledgements above. I hereby | consent to |
| | I hereby au | | acists of British Columbia to conduc | | ngoing basis |
| | every five y | ears. I understand that I may | y withdraw this consent for future c | riminal record checks. | |
| | | | | | |
| | | | | | |

Applicant signature



INTERNATIONAL PHARMACY GRADUATE (IPG)

CHECKLIST

You must submit

| 1. | | Checklist (page 1). |
|-----|------|--|
| 2. | | Application form (page 2). |
| 3. | | Copy of birth certificate or Canadian citizenship card. |
| 4. | | Copy of university degree(s). |
| 5. | | Copy of PEBC letter confirming completion of PEBC Evaluating Exam. |
| 6. | | Letter of current standing to be mailed to College office directly from applicant's existin regulatory authorities. Letter must be dated within three months prior to the date of th application. |
| 7. | | Notarized identification (use form on page 3), |
| 8. | | Statutory declaration (use form on page 4). |
| 9. | | Criminal record check authorization (use form on page 5). |
| Y | ou r | nust submit IF |
| 10. | | Copy of name change or marriage certificate - if name on any document is different from legal name. |
| 11. | | 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. |
| 12. | | 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 |

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.

and must be mailed to the college office directly from the regulatory bodies.



APPLICATION FOR PRE-REGISTRATIONINTERNATIONAL PHARMACY GRADUATE (IPG)

Application Form

| | | CONTACT INFORMATION | N | |
|----------------|--------------------------------|---------------------------------------|--------------------------|----------------------------|
| | □ Ms □ Mrs □ Miss | G □ Mr □ Dr | | |
| Legal name | (5 | First same | Otherwood (c) | |
| Address | Last name (Surname) | First name | Other name(s) Tel (home) | |
| | | | Tel (work) | |
| | | | | |
| | City | Province | Email | |
| | Postal code | Country | | |
| | | | | |
| | | | | |
| | | OTHER INFORMATION | | |
| | | OTHER INFORMATION | | |
| 1) Educatio | on University/Country | | | |
| | Degree/Year | | | |
| 2) Birth da | te YYYY-MM -DD | | | YES NO |
| | | | of Dhamas sister of DC2 | |
| 3) Is this the | ne first time you nave applied | for pre-registration with the College | e of Pharmacists of BC? | |
| | | | | |
| | | | | |
| | | PAYMENT OPTION | | |
| ☐ Chec | ue/Money order (payable to | College of Pharmacists of BC) | | |
| □ VISA | | | Application f | ee * 335.00 |
| | | _ | GST | 16.75 |
| Card # | | Exp _ | / Total | \$351.75 ———— |
| Cardhold | | | | GST # R106953920 |
| Cardhold | er signature | | * * Inclu | udes criminal record check |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | Date | | Applicant signature | |



INTERNATIONAL PHARMACY GRADUATE (IPG)

Notarized Identification

| | APPLICANT INF | FORMATION | |
|---|--|--|-----------------|
| Applicant name | | | |
| | | | |
| Required Documents | | | |
| Passport photograph, taken with | | | |
| Copy of name change or marriage from legal name. | je certificate if name on ar | ny document is different | |
| Required identification - one | orimary and one seco | ndary. | Photo |
| Identification presented to the Nissued by the government agence by the issuing government agence | y. Photocopies are accepta | ble only if certified | |
| PRIMARY | , | SECONDARY | |
| Document type | Document number | Document type | Document number |
| ☐ Birth certificate | 9 | Passport | |
| ☐ Canadian citizen card | (6) | Valid Canadian driver's license | |
| ☐ Canadian identity card | | British Columbia identification card | |
| | Q | Naturalization certificate | |
| | | Canadian Forces identification | |
| Date | NOTARY PUBLIC C | Applicant signate | ure |
| | | | |
| I hereby verify that the person shown Whose name appears as the Whose identity has been put Whose signature on this do | e Applicant. roven to my satisfaction the | rough presentation of the identification | on indicated. |
| Date | | Notary signatur | re |
| | Notary | name | |
| | · | | |
| SEAL | A | ddress | |
| | | | |
| | | Tel | |



INTERNATIONAL PHARMACY GRADUATE (IPG)

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 de | clare | e the facts set out herein to be true. | | | |
| | | Date Applicant signature | | | |



APPLICATION FOR PRE-REGISTRATIONINTERNATIONAL PHARMACY GRADUATE (IPG)

Criminal Record Check Authorization

| | APPLICANT INFORMATION | | | | |
|---------------|-----------------------------------|---|---|--|-----------------|
| Lega | al name | | | | |
| | ing address | Last name (Surname) | First name | Other name(s) | |
| Maii | ing address | Street | City/town | Province/State | Postal Code |
| | | Country | Contact phone | Area code | |
| Gen | der | □ Male □ Female | B.C. Driver License | | |
| Birth | n date | | Birthplace | | |
| | | YYYY-MM-DD | City/town name, birth name, previous married name) | Province/State | Country |
| Othe | | u of flave used (e.g. filaldeli i | iame, birth hame, previous marned hame) | | |
| | 1. | Surname | First name | Middle name | |
| | 2. | Surname | First name | Middle name | |
| | 3. | Surname | First name | Middle game | |
| | | Sumame | First Hallie | Middle Marrie | |
| | | FREEDOM OF INFO | RMATION AND PROTECTION OF | PRIVACY ACT (FOIPPA) | |
| | | | d under the authority of the Criminal Records | | |
| Comr the C | munity Care Fa Criminal Record | acility Act, and the regulations ds Review Act for the release o | which govern both these acts. The informatio f criminal records information and is in compli | n provided will be used to fulfill the rediance with the FOIPPA. | quirements of |
| | | CONCENT FOR R | ELEACE OF THE ORY ATTON, AND A | CKNOW! EDGEMENTS | |
| | | | ELEASE OF INFORMATION AND A | | |
| | | Pursu | ant to the B.C. Criminal Records F | Review Act | |
| • | | sent to a check for records of offences under the Criminal Re | criminal convictions to determine whether I ecords Review Act. | have a conviction or outstanding char | rge for |
| • | I hereby autl | horize the release to the Depu | ty Registrar any documents in the custody of relevant offence as defined under the Crimina | | sel relating to |
| • | | esults of this check indicate that the to verify any such criminal | at a criminal record or outstanding charge forecord. | r a relevant offence may exist, I agre | e to provide |
| • | | Registrar will notify me and mass been referred to the Deputy | y organization that I have an outstanding ch Registrar. | arge or conviction for any relevant off | fence(s) and |
| • | | | er or not I present a risk to physical or sexual | | |
| • | The Deputy F I have receiv | | e disclosed to my organization and it will incl | ude consideration of any relevant offer | nce for which |
| • | agree to repo | | ant offence at any time subsequent to the cri my organization and provide my organization, | · · | |
| | "Deputy Regist | trar" means a person appointed unde | er the Public Service Act as deputy registrar for the pu | urposes of this Act. | |
| | | | | | |
| | I have read | land understood the Cons | ant for Dologgo of Information and Ackn | owledgements above. I hereby so | ancont to |
| | | s as indicated by my signal | ent for Release of Information and Ackn ture below. | lowledgements above. I hereby co | onsent to |
| | | | rmacists of British Columbia to conduct may withdraw this consent for future cri | | oing basis |
| | | | | | |
| | | | | | |
| | | | | | |
| | | Date | | Applicant signature | |



Page 1 of 3



APPLICATION FORTEMPORARY PHARMACIST REGISTRATION

| | | APPLICANT INFORMA | TION |
|--------------|-------------------------------------|-------------------------------------|--|
| | ☐ Ms ☐ Mrs ☐ I | Miss | |
| Name | | | |
| Name | Last name (Surname) | First name | Other name(s) |
| Address | | | Tel (home) |
| | | | Tel (work) |
| | City | Province | Email |
| | | | |
| | Postal code | Country | |
| | | PAYMENT OPTIO | N |
| | | | |
| □ Cheq | ue/Money order (payable to | College of Pharmacists of BC) | |
| □ VISA | ☐ MasterCard | | Registration fee 157.50 |
| Card # | | Exp | |
| Cardholder | name | AV | Total <u>\$165.38</u> |
| Cardholder | signature | | GST # R106953920 |
| | | | |
| | | | |
| | | | |
| | | | harmacy Operations and Drug Scheduling Act, the |
| Pharmacists | s Regulation and the Bylaws | of the College of Pharmacists (| of British Columbia made pursuant to these Acts. |
| I have profe | essional liability insurance tha | at meets the following criteria | : |
| | Provides a minimum of \$2 million | coverage. | |
| | | ge or claims made with extended rep | |
| | If not in the pharmacists' name, th | e group policy covers the pharmacis | t as an individual. |
| I have signe | ed and attached: | | |
| | Statutory Declaration (use form of | n page 2). | |
| | Pharmacists Confidentiality Undert | aking (use form on page 3). | |
| | | | |
| | | | |
| | | | |
| | Date | | Applicant signature |



APPLICATION FOR TEMPORARY 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 (, , , , , , , , , , , , , , , , , , |
|----|------|-----|---|
| , | | 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. |
| | | | |
| Ιc | lecl | are | the facts set out herein to be true. |
| | | | Date Applicant signature |





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TEMPORARY PHARMACIST REGISTRATION

APPLICATION FOR

Pharmacist Confidentiality Undertaking

| _ | to access the PharmaNet clinical and patient database owing terms and conditions: | through the in-pharmacy computer system, o |
|---|--|--|
| | I will not access or use any clinical or patient information Pharmacy computer system for any purpose other than Act, the Pharmacy Operations and Drug Scheduling Act of BC made pursuant to these Acts. | those authorized by the Health Professions |
| | I agree at all times to treat as confidential all informat not participate in or permit, the unauthorized release information to any person, corporation or other entity by the Health Professions Act, the Pharmacy Operation the College of Pharmacists of BC made pursuant to the | , publication or disclosure of the said under any circumstances except as authorized s and Drug Scheduling Act and the Bylaws of |
| | I agree at all times, to treat as confidential all informa management of the PharmaNet database and the in- | |
| | I agree to be bound by the provisions of this agreement following termination of employment in the pharmacy | |
| | I agree to adhere to all policies and procedures issued the pharmacy owner, consistent with legislation, polic College of Pharmacists of British Columbia or the Provi confidentiality, privacy and security of the patient or cl database and the in-pharmacy computer database. | cies, procedures and standards issued by the nce of British Columbia, related to the |
| | Date | Applicant signature |

Note:

- 1. Attach original with application for registration.
- 2. Make a copy for the pharmacy manager to be retained in the pharmacy files.



STUDENT PHARMACIST (UBC) REGISTRATION

Please submit this application to the College of Pharmacists of BC

CHECKLIST

You must submit

Checklist (page 1).

| 2. | | Application form (page 2). |
|-----|------|---|
| 3. | | Copy of birth certificate or Canadian citizenship card (both sides). |
| 4. | | Copy of letter from UBC confirming registration with Faculty of Pharmacy. |
| 5. | | Notarized identification (use form on page 3). |
| 6. | | Statutory declaration (use form on page 4). |
| 7. | | Criminal record check authorization (use form on page 5). |
| Y | ou n | nust submit IF |
| 8. | | Copy of name change or marriage certificate - if name on any document is different from legal name. |
| 9. | | 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. |
| 10. | | 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 |

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.

must be mailed to the college office directly from the regulatory bodies.



STUDENT PHARMACIST (UBC) REGISTRATION

Application Form

| | | CONTACT INFORM | MATION | |
|---------------|-------------------------------|----------------------------------|--|--------------------------------|
| Legal name | □ Ms □ Mrs □ I | Miss | | |
| | Last name (Surname) | First name | Other name(s) | |
| Address | | | | |
| | | | Tel (work) | |
| | City | Province | Email | |
| | Postal code | Country | | |
| | | | | |
| | | | | |
| | | OTHER INFORM | MATION | |
| 1) Education | on UBC Student ID # | | | |
| 2) Birth da | ate YYYY-MM -DD | | | YES NO |
| 3) Is this t | he first time you have applie | ed for pre-registration with the | e College of Pharmacists of BC? | |
| | | | | |
| | | PAYMENT OPT | ION | |
| | | | | |
| | | to College of Pharmacists of BC) | Applicatio | n fee * 177.50 |
| □ VISA | A ☐ MasterCard | | GST | 8.88 |
| | | | Exp/ Total | <u>\$186.38</u> |
| | ler name | | | GST # R106953920 |
| Cardhold | ler signature | | | |
| | | | * | Includes criminal record check |
| | | | | |
| | | | | |
| | | | | |
| T banaba anat | havina tha Callana af Dhawsa | sists of Duitish Columbia to di | | |
| University of | British Columbia for the pu | rposes of compliance with the | sclose my criminal record check in Criminal Records Review Act. | iormation to tile |
| | | | | |
| | | | | |
| | Data | | Applicant sign-to- | |
| | Date | | Applicant signature | |



STUDENT PHARMACIST (UBC) REGISTRATION

Notarized Identification

| | APPLICANT INFORMATION | |
|---|---|---|
| | | _ |
| Applicant name | | |
| Required Documents | | |
| Passport photograph, taken within one ye | ear, affixed to space provided. | |
| | cate if name on any document is different | |
| from legal name. | | |
| Required identification - one prima | ary and one secondary. | |
| Identification presented to the Notary Pub | olic must be the original document | |
| issued by the government agency. Photocology the issuing government agency to be to | | |
| by the issuing government agency to be t | true copies of the original. | |
| | | |
| PRIMARY | SECONDARY | |
| ,, | nt number Document type Document number | |
| ☐ Birth certificate | Passport | |
| ☐ Canadian citizen card | Valid Canadian driver's license | |
| Canadian identity card | British Columbia identification card | |
| | □ Naturalization certificate □ Canadian Forces identification | |
| | La Calladian Forces Identification | |
| | | |
| | | |
| | | |
| Date | Applicant signature | |
| | | |
| NOT | TARY PUBLIC CERTIFICATION | |
| | | |
| I hereby verify that the person shown in the p | hotograph affixed on this page is the same person: | |
| Whose name appears as the Applica | ant. | |
| | my satisfaction through presentation of the identification indicated. | |
| Whose signature on this document v | was signed in my presence. | |
| | | |
| | | |
| Data | Makawa si na shawa | |
| Date | Notary signature | |
| | Notary name | |
| | * | |
| SEAL | Address | |
| | | |
| | T-1 | |



STUDENT PHARMACIST (UBC) 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 decla | re t | he facts set out herein to be true. |
| _ | | Date Applicant signature |



STUDENT PHARMACIST (UBC) REGISTRATION

Criminal Record Check Authorization

| | | | APPLICANT INFORMATION | | |
|----------|------------------------------|---|---|---|---------------------------------------|
| Legal r | name | | | | |
| _ | | Last name (Surname) | First name | Other name(s) | · · · · · · · · · · · · · · · · · · · |
| Mailing | address | Street | City/town | Province/State | Postal Code |
| | | Country | Contact phone | eArea code | |
| Gende | r | □ Male □ Female I | B.C. Driver License | | |
| Birth d | ate | | Birthplace | | |
| | | YYYY-MM-DD | City/town | Prevince/State | Country |
| Other | names used | d or have used (e.g. maiden na | ame, birth name, previous married name) | | |
| | 1. | Surname | First name | Middle name | |
| | 2. | Surname | First name | Middle name | |
| | 3. | | | | · · · · · · · · · · · · · · · · · · · |
| | | Surname | First name | Middle pame | |
| | | FREEDOM OF INFO | RMATION AND PROTECTION OF | FPRIVACY ACT (FOIPPA) | |
| The info | ormation req | quested on this form is collected | I under the authority of the Criminal Recor | ds Review Act and in the case of child care | e facilities, the |
| Commu | nity Care Fa ninal Record | acility Act, and the regulations was Review Act for the release of | which govern both these acts. The informat criminal records information and is in com | tion provided will be used to fulfill the requipliance with the FOIPPA. | irements of |
| | | | | | |
| | | | ELEASE OF INFORMATION AND | | |
| | | Pursua | ant to the B.C. Criminal Records | Review Act | |
| | | sent to a check for records of offences under the Criminal Re | criminal convictions to determine whether | I have a conviction or outstanding charg | e for |
| • I | hereby auth | norize the release to the Deput | y Registrar any documents in the custody elevant offence as defined under the Crimi | | el relating to |
| | | sults of this check indicate that its to verify any such criminal re | t a criminal record or outstanding charge ecord. | for a relevant offence may exist, I agree | to provide |
| | | Registrar will notify me and my as been referred to the Deputy | organization that I have an outstanding Registrar. | charge or conviction for any relevant offe | nce(s) and |
| • Th | he Deputy R | Registrar will determine whether | or not I present a risk to physical or sexu | al abuse to children. | |
| | | Registrar's determination will be ed a pardon. | e disclosed to my organization and it will in | clude consideration of any relevant offenc | e for which |
| ag | gree to repo | | nt offence at any time subsequent to the c ny organization and provide my organization | · · · · · · · · · · · · · · · · · · · | |
| "1 | Deputy Regist | rar" means a person appointed unde | r the Public Service Act as deputy registrar for the | e purposes of this Act. | |
| | | | | | |
| | | and understood the Conse s as indicated by my signat | nt for Release of Information and Acl ure below. | knowledgements above. I hereby cor | nsent to |
| | | | macists of British Columbia to conduc nay withdraw this consent for future o | | ng basis |
| | | | | | |
| | | | | | |
| | | | | | |

Applicant signature

Date



STUDENT PHARMACIST (NON UBC) REGISTRATION

Please submit this application to the College of Pharmacists of BC

CHECKLIST

You must submit

| 1. | Checklist (page 1). |
|----|--|
| 2. | Application form (page 2). |
| 3. | Copy of birth certificate or Canadian citizenship card (both sides). |
| 4. | Copy of student ID card (both sides). |
| 5. | Notarized identification (use form on page 3). |
| 6. | Statutory declaration (use form on page 4). |
| 7. | Criminal record check authorization (use form on page 5). |

You must submit IF

| 8. | | Copy of name change or marriage certificate - if name on any document is |
|-----|---|--|
| | | different from legal name. |
| 0 | | Evidence of your puttorization to work in Canada, if you are not a Canadian citizen |
| 9. | Ш | 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. |
| 10. | | 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 PRE-REGISTRATIONSTUDENT PHARMACIST (NON UBC) REGISTRATION

Application Form

| | | CONTACT INFORMAT | ION | |
|--------------|-------------------------------|-------------------------------------|---|----------------------------------|
| | □ Ms □ Mrs □ M | liss | | |
| Legal name | Last name (Gunnama) | Floring | Other many (a) | |
| Address | Last name (Surname) | First name | Other name(s) Tel (home) | |
| | | | Tel (work) | |
| | | | | |
| | City | Province | Email | |
| | Postal code | Country | | |
| | | | | |
| | | | | • |
| | | OTHER INCORMATION | | |
| | | OTHER INFORMATION | ON | |
| 1) Education | on Student ID # | | | |
| -, | Canadian University | | | |
| 2) Birth da | | | | YES NO |
| · | | | | |
| 3) Is this t | he first time you have applie | d for pre-registration with the Col | lege of Pharmacists of BC? | |
| | | | | |
| | | | | |
| | | PAYMENT OPTION | l de la companya de | |
| П | (1) | | | |
| | | to College of Pharmacists of BC) | Applica | tion fee * 177.50 |
| □ VISA | | | GST | 8.88 |
| Card # | | Ex | p/ Total | \$186.38 |
| Cardhold | er name | V | | GST # R106953920 |
| Cardhold | er signature | | | * Includes criminal record check |
| | | | | Includes criminal record check |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | Date | | Applicant signatu | re |



STUDENT PHARMACIST (NON UBC) REGISTRATION

Notarized Identification

| AP | PLICANT INFORMATION |
|---|--|
| | |
| Applicant name | |
| Required Documents | |
| Passport photograph, taken within one year, | , affixed to space provided. |
| Copy of name change or marriage certificate | e if name on any document is different |
| from legal name. | |
| Required identification - one primary a | nd one secondary. |
| Identification presented to the Notary Public | must be the original document |
| issued by the government agency. Photocop by the issuing government agency to be true | |
| by the issuing government agency to be true | e copies of the original. |
| | |
| PRIMARY | SECONDARY |
| Document type Document no | 7 |
| ☐ Birth certificate | Passport |
| ☐ Canadian citizen card | Valid Canadian driver's license |
| ☐ Canadian identity card | British Columbia identification card Naturalization certificate |
| | Canadian Forces identification |
| | 2 Canada i Sicci identificación |
| Date | Applicant signature |
| NOTAL | RY PUBLIC CERTIFICATION |
| I hereby verify that the person shown in the phot Whose name appears as the Applicant. Whose identity has been proven to my Whose signature on this document was | r satisfaction through presentation of the identification indicated. |
| Date | Notary signature |
| | Notary name |
| SEAL | Address |
| | |
| | |
| | Tel |



STUDENT PHARMACIST (NON UBC) 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 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 ded | clare | e the facts set out herein to be true. |
| | _ | Date Applicant signature |



APPLICATION FOR PRE-REGISTRATIONSTUDENT PHARMACIST (NON UBC) REGISTRATION

Criminal Record Check Authorization

| | | | APPLICANT INFORMATION | | |
|--------|-------------------------------|--|--|---|----------------------|
| Lea | al name | | | | |
| | | Last name (Surname) | First name | Other name(s) | |
| Mail | ling address | Street | City/town | Province/State | Postal Code |
| | | Country | Contact phone | Area code | |
| Gen | ıder | ☐ Male ☐ Female B.0 | C. Driver License | | |
| Rirt | h date | Rir | thplace | | |
| | | YYYY-MM-DD | City/town | Province/State | Country |
| Oth | er names use | d or have used <i>(e.g. maiden nam</i> | ne, birth name, previous married name) | | |
| | 1. | Surname | First name | Middle name | |
| | 2. | Surname | First name | Middle name | |
| | 3. | | | | |
| | | Surname | First name | Middle páme | |
| | | FREEDOM OF INFOR | MATION AND PROTECTION OF | PRIVACY ACT (FOIPPA) | |
| The i | information red | quested on this form is collected u | under the authority of the Criminal Records | s Review Act and in the case of child | care facilities, the |
| Com | munity Care Fa | acility Act, and the regulations wh | ich govern both these acts. The information in the information and is in comp | on provided will be used to fulfill the | |
| tile t | Zillilliai Record | as Review Act for the release of the | illililai records information and is in comp | mance with the FOIFFA. | |
| | | CONSENT FOR REL | EASE OF INFORMATION AND A | ACKNOWLEDGEMENTS | |
| | | Pursuan | t to the B.C. Criminal Records | Review Act | |
| • | | | minal convictions to determine whether I | I have a conviction or outstanding c | charge for |
| | • | offences under the Criminal Reco | rds Review Act. Registrar any documents in the custody o | of the police, the court and crown co | ounsel relating to |
| | an outstandir | ng charge or conviction of any rele | evant offence as defined under the Crimin | al Records Review Act | - |
| • | | esults of this check indicate that a first to verify any such criminal reco | a criminal record or outstanding charge for ord. | or a relevant offence may exist, I a | gree to provide |
| • | The Deputy I | Registrar will notify me and my o as been referred to the Deputy Re | rganization that I have an outstanding ch | harge or conviction for any relevant | offence(s) and |
| • | | | r not I present a risk to physical or sexua | al abuse to children. | |
| • | The Deputy F I have receiv | | isclosed to my organization and it will inc | clude consideration of any relevant o | ffence for which |
| • | agree to repo | | offence at any time subsequent to the cr organization and provide my organization | | · |
| | | | he Public Service Act as deputy registrar for the p | purposes of this Act. | |
| | | | | | |
| | | | | | |
| | | l and understood the Consent s as indicated by my signatur | for Release of Information and Acking below. | nowledgements above. I hereby | consent to |
| | | | acists of British Columbia to conduct y withdraw this consent for future cr | | ngoing basis |
| | | | | | |
| | | | | | |
| | | | | | |

Applicant signature

Date



Page 1 of 3

APPLICATION FOR



PHARMACY TECHNICIAN REGISTRATION

| | | APPLICANT INFORM | ATION |
|-------------|----------------------------------|--------------------------------|---|
| | ☐ Ms ☐ Mrs ☐ | Miss | |
| Name | | | |
| Name | Last name (Surname) | First name | Other name(s) |
| Address | | | Tel (home) |
| | | | Tel (work) |
| | | | Email |
| | City | Province | |
| | Postal code | Country | |
| | | PAYMENT OPTION | |
| | | PAIMLNI OF IIC | |
| □ Che | eque/Money order (payable to Col | lege of Pharmacists of BC) | |
| | SA □ MasterCard | | |
| Card # | | Exp | Registration fee 420.00 GST 21.00 |
| - | | | Total \$441.00 |
| Cardholde | er name | | GST # R106953920 |
| | | | |
| | | | |
| I attest th | at I am in compliance with the | Health Professions Act, the | Pharmacy Operations and Drug Scheduling Act, the of British Columbia made pursuant to these Acts. |
| | | | |
| | | _ | a (please check the box(es) below): |
| | Provides a minimum of \$2 n | | |
| | | | extended reporting period of at least 3 years. the pharmacist as an individual. |
| Ц | in not in the pharmacists he | ine, the group policy covers | ane pharmacist as an mulvidual. |
| I have sig | ned and attached (please ched | k the box(es) below): | |
| | Statutory Declaration (use f | orm on page 2). | |
| | Pharmacy Technician Confid | entiality Undertaking (use for | rm on page 3). |
| | | | |
| | | | |
| | | | |
| | Date | | Applicant signature |



Statutory Declaration (Form 5)

PHARMACY TECHNICIAN REGISTRATION

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. 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 de | clar | e the facts set out herein to be true. |
| | | |
| | | |
| | | |

Applicant signature

Date







APPLICATION FORPHARMACY TECHNICIAN REGISTRATION

Pharmacy Technician Confidentiality Undertaking

| _ | to access the PharmaNet clinical and patient database through the in-pharmacy computer system, on owing terms and conditions: |
|---|--|
| | I will not access or use any clinical or patient information in the PharmaNet database or the in- Pharmacy computer system for any purpose other than those authorized by the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act and the Bylaws of the College of Pharmacists of BC made pursuant to these Acts. |
| | I agree at all times to treat as confidential all information referred to in paragraph (1) and will not participate in or permit, the unauthorized release, publication or disclosure of the said information to any person, corporation or other entity under any circumstances except as authorized by the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act and the Bylaws of the College of Pharmacists of BC made pursuant to these Acts. |
| | I agree at all times, to treat as confidential all information relating to the security and management of the PharmaNet database and the in-pharmacy computer system. |
| | I agree to be bound by the provisions of this agreement and will continue to do so following termination of employment in the pharmacy for any reason. |
| | I agree to adhere to all policies and procedures issued by the pharmacy manager and/or the pharmacy owner, consistent with legislation, policies, procedures and standards issued by the College of Pharmacists of British Columbia or the Province of British Columbia, related to the confidentiality, privacy and security of the patient or clinical information contained in the PharmaNet database and the in-pharmacy computer database. |
| | Date Applicant signature |

Note:

- 1. Attach original with application for registration.
- 2. Make a copy for the pharmacy manager to be retained in the pharmacy files.



CURRENT PHARMACY TECHNICIAN (PRE-2015)

Please submit this application to the College of Pharmacists of BC

CHECKLIST

You must submit

Checklist (page 1).

| 2. | | Application form (page 2). |
|-----|------|---|
| 3. | | Copy of birth certificate or Canadian citizenship card (both sides). |
| 4. | | Evidence of English Language Proficiency (ELP). (Copy of transcript or diploma that confirms graduation from a secondary school, university, community college, private vocational program or equivalent in Canada or the continental U.S. or a NAPRA recognized ELP assessment for pharmacy technicians.) |
| 5. | | Notarized identification (use form on page 3). |
| 6. | | Employment certification (use form on page 6). (Not required if PEBC letter confirming completion of PEBC Evaluating Exam is provided.) |
| 7. | | Statutory declaration (use form on page 4). |
| 8. | | Criminal record check authorization (use form on page 5). |
| Y | ou m | nust submit IF APPLICABLE |
| 9. | | Copy of name change or marriage certificate - if name on any document is different from legal name. |
| 10. | | 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. |
| 11. | | 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. |
| 12. | | Copy of PEBC letter confirming completion of PEBC Evaluating Exam. |
| 13. | | Copy of pharmacy technician certificate from PTCB-AB or OCP (up to 2008). |
| 14. | | Copy of university degree from an accredited pharmacist degree program in Canada or in the continental United States. |

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 PRE-REGISTRATIONCURRENT PHARMACY TECHNICIAN (PRE-2015)

Application Form

| Legal name Home Address Work Address | Last name (Surname) City Postal code Street Address | Mr Dr First name Province Country | Other name(s) Tel (home) Email PharmaCare Code Tel (work) | |
|--|--|--------------------------------------|--|-----------------------------|
| Home Address | City Postal code Pharmacy Name | Province Country | Tel (home) Email PharmaCare Code | |
| | City Postal code Pharmacy Name | Country | Tel (home) Email PharmaCare Code | |
| Work Address | Postal code Pharmacy Name | Country | PharmaCare Code | |
| Work Address | Postal code Pharmacy Name | Country | X/ | |
| Work Address | Postal code Pharmacy Name | Country | X/ | |
| Work Address | Pharmacy Name | | X/ | |
| Work Address | | City | X/ | , |
| | | City | Tel (work) | |
| | Street Address | City | lei (work) | |
| | | | | |
| | | | | |
| | | | | |
| | | OTHER INFORMATION | | |
| 1) Education F | rogram/Country | | | |
| | Certification/Year | | | |
| 2) Birth date | YYYY-MM -DD | | | YES NO |
| 3) Is this the first til | the you have applied for pre- | PAYMENT OPTION | e of Frialmacists of BC: | |
| ☐ Cheque/Mo | ney order (payable to College | of Pharmacists of BC) | F | |
| □ VISA | ☐ MasterCard | | Application f | |
| Card # | | Exp | / GST / Total | 11.50 \$241.50 |
| Cardholder name | | | | |
| Cardholder signatu | ıre | | | GST # R106953920 |
| | | | * Incl | ludes criminal record check |
| | | | | |
| | Date | | Applicant signature | |



CURRENT PHARMACY TECHNICIAN (PRE-2015)

Notarized Identification

| | | | APPLICANT | INFORMA | TION | |
|-------|--|----------------------------|---------------------------|---------------|---------------------------------|-----------------|
| | | | | | | |
| Appli | cant na | me | | | | |
| Rea | uired | Documents | | | | |
| | Passport photograph, taken within one year, affixed to space provided. | | | ded. | | |
| | | of name change or marr | | | | |
| | | legal name. | | , | | |
| Rea | uired | identification - one | primary and one se | condary. | | Photo |
| • | | ification presented to the | | _ | document | |
| | | by the government age | | | | |
| | by the | e issuing government age | ency to be true copies of | the original. | | |
| | | | | | | |
| | | PRIMA | RY | · | SECONDARY | |
| | | Document type | Document number | | Document type | Document number |
| | | Birth certificate | | ☐ Pass | port | |
| | | Canadian citizen card | • | ☐ Valid | Canadian driver's license | |
| | | Canadian identity card | | ☐ Britis | sh Columbia identification card | |
| | | | | □ Natu | ralization certificate | |
| | *************************************** | | | ☐ Cana | dian Forces identification | |
| | | · | | | | |
| | | | | | | |
| | | | | | | |
| | | Date | | = | Applicant signa | ture |
| | | | | | | |
| | | | NOTARY PUBL | IC CERTIFI | CATION | |
| | | | | | | |
| I he | ereby v | erify that the person sho | wn in the photograph aff | fixed on this | page is the same person: | |
| | | | | | , | |
| | | hose name appears as the | | through pro | contation of the identification | n indicated |
| | | hose signature on this do | | | sentation of the identification | i ilidicated. |
| | | | | ., | | |
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| | | | | | | |
| | | Date | | | Notary signatu | ire |
| | | | N | otany namo | | |
| | | | IN | otary name | | |
| | | SEAL | | Address | | |
| | | | | | | |
| | | | | • | | |
| | | | | Tel | | |



CURRENT PHARMACY TECHNICIAN (PRE-2015)

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

| | | 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. |
| decl | are | the facts set out herein to be true. |
| | | |
| | | Date Applicant signature |



CURRENT PHARMACY TECHNICIAN (PRE-2015)

Criminal Record Check Authorization

| | | | APPLICANT INFORMATION | N | |
|-------|--|---|--|--|--|
| Leg | al name | Last name (Surname) | First name | Other name(s) | |
| Mail | ling address | | | | |
| | | Street | City/town | Province/State | Postal Code |
| | | Country | Contact phor | Area code | |
| Gen | ıder | □ Male □ Female | B.C. Driver License | | |
| Birtl | h date | YYYY-MM-DD | Birthplace | Drawings (Chate | Country |
| Oth | er names use | | name, birth name, previous married name) | Province/State | Country |
| | 4 | , - | , | | |
| | 1. | Surname | First name | Middle name | |
| | 2. | Surname | First name | Middle name | |
| | 3. | | | | ···· |
| | | Surname | First name | Middle name | |
| | | FREEDOM OF INFO | RMATION AND PROTECTION O | F PRIVACY ACT (FOIPPA) | |
| Com | munity Care Fa | acility Act, and the regulations | d under the authority of the Criminal Reco which govern both these acts. The informa f criminal records information and is in con | ation provided will be used to fulfill the | |
| | | CONSENT FOR R | ELEASE OF INFORMATION AND | ACKNOWLEDGEMENTS | |
| | any relevant I hereby auth an outstandir Where the re my fingerprin The Deputy F the matter ha The Deputy R I have receive If I am charg agree to repo a Criminal Re | sent to a check for records of confences under the Criminal Reports the release to the Deputing charge or conviction of any insults of this check indicate that to verify any such criminal registrar will notify me and make been referred to the Deputy stegistrar will determine whether the degistrar's determination will be deal a pardon. The definition of the convicted of a relevant the charge or conviction to a coord Check form. | ty Registrar any documents in the custody relevant offence as defined under the Crim at a criminal record or outstanding charge record. | have a conviction or outstanding chain of the police, the court and crown control of the police, the court and crown control of the police, the court and crown control of the police of | pounsel relating to gree to provide c offence(s) and offence for which in, I further |
| | | | | | |
| | | and understood the Conses as indicated by my signat | ent for Release of Information and Acture below. | cknowledgements above. I hereby | y consent to |
| | | | macists of British Columbia to condu nay withdraw this consent for future | | ongoing basis |
| | | | | | |

Applicant signature

Date



CURRENT PHARMACY TECHNICIAN (PRE-2015)

Employment Certification

STATEMENT OF COMPLETION OF REQUIRED HOURS OF WORK

| PRINT app | plicant name | |
|--|---|---|
| have completed 2,000 hours of work with the requirements of The Pharma | in the past 36 months in Canada, as cacy Examining Board of Canada (refer | cited below, in the field of pharmacy and in complition to Appendix) " Criteria for Field of Pharmacy". |
| | | |

| Pharmacy Name, Address and Telephone Number Name:Address: Tel: Address:Address: | Job Title of Applicant Pharmacy Assistant/ Technician Volunteer Other (please specify): Pharmacy Assistant/ Technician Volunteer Other (please specify): | Date Started & Hours Worked in 36 Months Date Started: (month/year) Hours/36months: Date Started: (month/year) Hours/36months: | Name: | *Signature of Supervising Pharmacist and Date Signature: Date: |
|--|---|--|--------|--|
| Address: Tel: Name: | Technician Volunteer Other (please specify): Pharmacy Assistant/ Technician Volunteer Other (please | (month/year) Hours/36months: Date Started: (month/year) | Reg #: | Date: |
| | Technician □ Volunteer □ Other (please | (month/year) | | Signature: |
| | | | Reg #: | Date: |
| Name: Address: | □ Pharmacy Assistant/ Technician □ Volunteer □ Other (please specify): | Date Started: (month/year) Hours/36months: | Name: | Signature: |
| Name:Address: | ☐ Pharmacy Assistant/ Technician ☐ Volunteer ☐ Other (please specify): | Date Started: (month/year) Hours/36months: | Name: | Signature: |
| Tel: Name: Address: Tel: | ☐ Pharmacy Assistant/ Technician ☐ Volunteer ☐ Other (please specify): | Date Started: (month/year) Hours/36months: | Name: | Signature: |

^{*}Statement of Declaration and Verification (to be signed for in the above table by pharmacist(s) supervising this applicant for the work hours cited):

I hereby certify that while working under my supervision, the applicant was working in a setting consistent with some or all of the activities outlined in the Appendix "Criteria for Field of Pharmacy". I also hereby certify that the information completed above is true and that I have been in direct supervision of this applicant. As such, I have printed and signed my name as a Statement of Declaration and Verification in the above table adjacent to the applicant's specified hours for those specified hours while he/she was under my supervision.



CURRENT PHARMACY TECHNICIAN (PRE-2015)

Employment Certification

APPENDIX: CRITERIA FOR FIELD OF PHARMACY

The field of pharmacy includes practice where some of the following tasks are performed:

PRESCRIPTION AND PATIENT INFORMATION PROCESSING

- Creating and maintaining patient records
- Receiving and transferring prescriptions or requests for prescription refills, including assessing prescriptions for clarity, completeness, authenticity and legal requirements
- Preparing products for release and/or distribution, including:
 - o Product selection
 - Retrieving, counting, pouring, weighing, measuring, compounding and reconstituting sterile and non-sterile products
 - Packaging products to maintain integrity, including selecting type of prescription container, pre-packaging medications and affixing prescription and auxiliary labels
- Releasing and distributing products in a manner that ensures patient safety

COMMUNICATION AND EDUCATION

 Communicating with patients, patients' agents, pharmacists, other pharmacy technicians and other members of the health care team, and educating, where appropriate, in order to promote and support optimal patient care and well-being

MANAGEMENT

 Managing operations, administrative activities, and financial elements associated with the processing of prescriptions

OTHER RELATED PHARMACY SERVICES

- Generating patient care data (i.e. medication administration record, medication review)
- Managing systems for drug distribution and inventory control to ensure patient safety and the safety, accuracy, quality, integrity and timeliness of the products, including:
 - Determining and maintaining inventory requirements
 - Auditing inventory and documenting discrepancies for narcotic, controlled, and targeted-controlled substances
- Maintaining drug information files
- Maintaining packaging and dispensing equipment and storage facilities
- Replenishing medications for nursing units, night cupboards, emergency boxes and cardiac arrest kits

PROFESSIONAL COLLABORATION AND TEAMWORK

 Working in collaborative relationships within health care teams to optimize patient safety and improve health outcomes

QUALITY ASSURANCE

 Collaborating in developing, implementing and evaluating quality assurance and risk management policies, procedures, and activities related to the safe use of medications and the safety and integrity of pharmaceutical products

Note:

These criteria are adapted from NAPRA's "Professional Competencies for Canadian Pharmacy Technicians at Entry to Practice".

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APPLICATION FOR PRE-REGISTRATION

CANADA - NEW PHARMACY TECHNICIAN GRADUATE

Please submit this application to the College of Pharmacists of BC

CHECKLIST

You must submit

Checklist (page 1).

| 2. | | Application form (page 2). |
|-----|------|---|
| 3. | | Copy of birth certificate or Canadian citizenship card (both sides). |
| 4. | | Copy of CCAPP accredited pharmacy technician program certificate(s). |
| 5. | | Notarized identification (use form on page 3). |
| 6. | | Statutory declaration (use form on page 4). |
| 7. | | Criminal record check authorization (use form on page 5). |
| Yo | ou m | oust submit IF APPLICABLE |
| 8. | | Copy of name change or marriage certificate - if name on any document is different from legal name. |
| 9. | | 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. |
| 10. | | 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 PRE-REGISTRATION CANADA - NEW PHARMACY TECHNICIAN GRADUATE

Application Form

| | | CONTACT INFORMA | TION | |
|-------------------|-------------------------------------|--|--------------------------|-------------------------|
| | □ Ms □ Mrs □ M | liss | | |
| Legal name | Last name (Surname) | First name | Other name(s) | |
| Home Address | | | Tel (home) | |
| | | | Email | |
| | | | | |
| | City | Province | | |
| | Postal code | Country | | |
| Work Address | | | PharmaCare Code | |
| | Pharmacy Name | | X / | |
| | Street Address | City | Tel (work) | |
| | | | | |
| | | | | |
| | | OTHER INFORMATION | N | |
| 1) Education | Program/Country | AX | | |
| i) Laucation | Program/Country Certification/Year | . 1 | | |
| 2) Birth date | YYYY-MM -DD | | | YES NO |
| , | | The state of the s | on of Pharmaciata of PC2 | |
| 3) Is this the fi | rst time you have applied for | pre-registration with the Collec | ge of Pharmacists of BC? | |
| | | | | |
| | | PAYMENT OPTION | | |
| | | | | |
| ☐ Chequ | e/Money order (payable to Co | llege of Pharmacists of BC) | | 1 |
| □ VISA | ☐ MasterCard | | Application fee GST | * 230.00 11.50 |
| Card # | | Exp _ | | \$241.50 |
| Cardholder na | ame | | | GST # R106953920 |
| Cardholder si | gnature | | | |
| | | | * Includes | s criminal record check |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | Date | | Applicant signature | |



CANADA - NEW PHARMACY TECHNICIAN GRADUATE

Notarized Identification

| | | | APPLICAN | T INFORMA | TION | |
|--------|---|---------------------------|--------------------------|------------------|---|-----------------|
| | | | | | | |
| Applic | ant na | me | | | | |
| D | | D | | | | |
| Keq | | 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. | | | | | |
| | Photo | | | | | |
| Requ | Required identification - one primary and one secondary. | | | | | FIIOCO |
| | | fication presented to the | - | _ | | |
| | | by the government age | | | | |
| | by the | e issuing government age | ency to be true copies o | i tile original. | | |
| | | | | | | |
| | | PRIMA | RY | • | SECONDARY | , |
| | | Document type | Document number | | Document type | Document number |
| | | Birth certificate | | ☐ Pass | port | |
| | | Canadian citizen card | | ☐ Valid | Canadian driver's license | |
| | | Canadian identity card | | ☐ Britis | sh Columbia identification card | |
| | | | | □ Natu | ralization certificate | |
| | *************************************** | | | ☐ Cana | dian Forces identification | |
| | <u></u> | 1 | | | • | |
| | | | | | | |
| | | | | | | |
| | | Date | | - | Applicant signat | cure |
| | | | | | 7 | |
| | | | | | | |
| | | | NOTARY PUBL | IC CERTIFI | CATION | |
| | | | | | | |
| I he | reby v | erify that the person sho | wn in the photograph a | ffixed on this | page is the same person: | |
| | - W | hose name appears as th | e Applicant. | | | |
| | • W | hose identity has been p | roven to my satisfactior | through pres | sentation of the identification | indicated. |
| | • W | hose signature on this do | ocument was signed in I | my presence. | | |
| | | | | | | |
| | | | | | | |
| | | Date | | | Notary signatu | |
| | | | | | , | |
| | | | | Notary name | | |
| | | | | • | | |
| | | SEAL | | Address | | |
| | | | | | | |
| | | | | | | |
| | | | | Tel | | |



CANADA - NEW PHARMACY TECHNICIAN GRADUATE

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 doc | laro | the facts set out herein to be true. |
| i dec | iaie | the facts set out herein to be true. |
| | | |
| | | |

Applicant signature

Date



CANADA - NEW PHARMACY TECHNICIAN GRADUATE

Criminal Record Check Authorization

| | | | APPLICANT INFORMATION | | |
|-------|--------------------------------|---|--|--|------------------|
| | | | | | |
| _ | al name | Last name (Surname) | First name | Other name(s) | |
| ман | ing address | Street | City/town | Province/State Posi | tal Code |
| | | Country | Contact phone | Area code | |
| Gen | der | □ Male □ Female | B.C. Driver License | | |
| | | | | | |
| Birt | h date | ryyy-MM-DD | Birthplace | Province/State Co | untry |
| Oth | er names used | d or have used (e.g. maiden n | ame, birth name, previous married name) | | |
| | 1. | Surname | First name | Mid dle N ame | |
| | 2. | Surname | First name | Middle Hame | |
| | 2 | Surname | First name | Middle name | |
| | 3. | Surname | First name | Middle name | |
| | | | | | |
| | | | RMATION AND PROTECTION OF I | | |
| The i | nformation req | uested on this form is collected | d under the authority of the Criminal Records which govern both these acts. The informatio | Review Act and in the case of child care facilities on provided will be used to fulfill the requirement | es, the ts of |
| | | | criminal records information and is in compl | | |
| | | CONSENT FOR RE | ELEASE OF INFORMATION AND A | CKNOWLEDGEMENTS | |
| | | Pursua | ant to the B.C. Criminal Records I | Review Act | |
| | | | | | |
| • | | sent to a check for records of cr offences under the Criminal Re | riminal convictions to determine whether I ha ecords Review Act. | ave a conviction or outstanding charge for | |
| • | I hereby auth an outstandin | norize the release to the Deputing charge or conviction of any r | cy Registrar any documents in the custody of relevant offence as defined under the Crimina | f the police, the court and crown counsel relating Records Review Act. | ng to |
| • | | sults of this check indicate that ts to verify any such criminal r | | r a relevant offence may exist, I agree to prov | ide |
| • | | Registrar will notify me and my as been referred to the Deputy | | arge or conviction for any relevant offence(s) a | and |
| • | The Deputy R | egistrar will determine whethe | r or not I present a risk to physical or sexual | abuse to children. | |
| • | The Deputy R I have receive | | e disclosed to my organization and it will incl | ude consideration of any relevant offence for w | hich |
| • | agree to repo | | | minal record check authorized herein, I further , in a timely manner, with a new-signed Consen | t to |
| | "Deputy Regist | rar" means a person appointed unde | er the Public Service Act as deputy registrar for the p | ourposes of this Act. | |
| | | | | | |
| _ | T beautiful ! | and understand the C | ant for Delegae of Information and Auto- | The state of the s | |
| | | and understood the Conse as indicated by my signat | | nowledgements above. I hereby consent to | 0 |
| | • | | macists of British Columbia to conduct nay withdraw this consent for future cri | criminal record checks on an ongoing bas iminal record checks. | sis |
| | | | | | |
| | | | | | |
| | | | | | |

Applicant signature

Date



Page 1 of 3



APPLICATION FORTEMPORARY PHARMACY TECHNICIAN REGISTRATION

| | | APPLICANT INFORMA | TION | |
|--------------|--|-------------------------------------|--|--|
| | ☐ Ms ☐ Mrs ☐ M | Miss | | |
| Nama | | | | |
| Name | Last name (Surname) | First name | Other name(s) | |
| Address | | | Tel (home) | |
| | | | Tel (work) | |
| | City | Drawings | Email | |
| | City | Province | | |
| | Postal code | Country | | |
| | | PAYMENT OPTION | | |
| | | | | |
| □ Cheq | ue/Money order (payable to 0 | College of Pharmacists of BC) | | |
| □ VISA | ☐ MasterCard | | Registration fee 105.00 | |
| Card # | | Exp | GST <u>5.25</u> | |
| Cardholder | name | | Total <u>\$110.25</u> | |
| Cardholder | GST # R106953920 Cardholder signature | | | |
| | | | | |
| | * | | | |
| | | | | |
| | | | narmacy Operations and Drug Scheduling Act, the | |
| Pharmacists | s Regulation and the Bylaws of | of the College of Pharmacists o | of British Columbia made pursuant to these Acts. | |
| I have profe | essional liability insurance tha | at meets the following criteria: | | |
| | Provides a minimum of \$2 million of | coverage. | | |
| | Provides occurrence based coverage | e or claims made with extended repo | orting period of at least 3 years. | |
| | If not in the pharmacy technician's | name, the group policy covers the p | harmacy technician as an individual. | |
| I have signe | ed and attached: | | | |
| | Statutory Declaration (use form o | n page 2). | | |
| | Pharmacy Technician Confidentialit | y Undertaking (use form on page 3). | | |
| | | | | |
| | | | | |
| | | | | |
| | Date | | Applicant signature | |



TEMPORARY PHARMACY TECHNICIAN 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 dec | lare | the facts set out herein to be true. |
| | | Date Applicant signature |



Page 3 of 3

0

APPLICATION FORTEMPORARY PHARMACY TECHNICIAN REGISTRATION

Pharmacy Technician Confidentiality Undertaking

| _ | to access the PharmaNet clinical and patient database owing terms and conditions: | through the in-pharmacy computer system, o |
|---|--|---|
| | I will not access or use any clinical or patient informat Pharmacy computer system for any purpose other than Act, the Pharmacy Operations and Drug Scheduling Act of BC made pursuant to these Acts. | n those authorized by the Health Professions |
| | I agree at all times to treat as confidential all informat not participate in or permit, the unauthorized release information to any person, corporation or other entity by the Health Professions Act, the Pharmacy Operation the College of Pharmacists of BC made pursuant to the | , publication or disclosure of the said under any circumstances except as authorized as and Drug Scheduling Act and the Bylaws of |
| | I agree at all times, to treat as confidential all informa management of the PharmaNet database and the in- | |
| | I agree to be bound by the provisions of this agreement following termination of employment in the pharmacy | |
| | I agree to adhere to all policies and procedures issued the pharmacy owner, consistent with legislation, polic College of Pharmacists of British Columbia or the Provi confidentiality, privacy and security of the patient or clutabase and the in-pharmacy computer database. | cies, procedures and standards issued by the nce of British Columbia, related to the |
| | Date | Applicant signature |
| | | |

Note:

- 1. Attach original with application for registration.
- 2. Make a copy for the pharmacy manager to be retained in the pharmacy files.







APPLICATION FORNON-PRACTISING PHARMACIST REGISTRATION

| | | APPLICANT INFORM | ATION |
|------------------------------|---|---|---|
| | ☐ Ms ☐ Mrs ☐ Mis | s | Reg # |
| Name | Last name (Surname) | First name | Other name(s) |
| Address | | | Tel (home) |
| | | | Tel (work) |
| | | | |
| | City | Province | Email |
| | Postal code | Country | _ |
| | | , | |
| | | PAYMENT OPTIC | ON |
| | | | <u> </u> |
| □ Cheq | ue/Money order (payable to Col. | lege of Pharmacists of BC) | |
| □ VISA | □ MasterCard | | 50.00 |
| | | Exp | Registration fee 504.00 GST 25.20 |
| | | | Total \$529.20 |
| | name | | GST # R106953920 |
| Cardholder | signature | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| I attest that Pharmacists | t I am in compliance with the F Regulation and the Bylaws of | lealth Professions Act, the the College of Pharmacists | Pharmacy Operations and Drug Scheduling Act, the of British Columbia made pursuant to these Acts. |
| | | | |
| I have signe | ed and attached: | | |
| | Statutory Declaration (use form on p | 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 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 de | clare | e the facts set out herein to be true. |
| | _ | Date Applicant signature |







APPLICATION FORNON-PRACTISING PHARMACIST REGISTRATION

Criminal Record Check Authorization

| | | | APPLICANT INFORMATION | | |
|-----------------|--------------------------------|--|--|--|---------------------------------------|
| Lea | al name | | | | |
| | | Last name (Surname) | First name | Other name(s) | |
| Mailing address | | Street | City/town | Province/State | Postal Code |
| | | Country | Contact phone | Area code | |
| Gen | der | ☐ Male ☐ Female B. | C. Driver License | | |
| Rirt | h date | Rir | thplace | | |
| | | YYYY-MM-DD | City/town | Province/State | Country |
| Oth | er names use | d or have used <i>(e.g. maiden nam</i> | ne, birth name, previous married name) | | |
| | 1. | Surname | First name | Middle name | |
| | 2. | Surname | First name | Mitdle name | |
| | 3. | | | | · · · · · · · · · · · · · · · · · · · |
| | | Surname | First name | Middle pame | |
| | | FREEDOM OF INFORI | MATION AND PROTECTION OF | PRIVACY ACT (FOIPPA) | |
| The i | nformation red | quested on this form is collected u | ander the authority of the Criminal Record | ds Review Act and in the case of child | care facilities, the |
| | | | ich govern both these acts. The informati | | requirements of |
| | | | | | |
| | | | EASE OF INFORMATION AND A | | |
| | | Pursuan | t to the B.C. Criminal Records | Review Act | |
| • | | sent to a check for records of cri offences under the Criminal Reco | minal convictions to determine whether | I have a conviction or outstanding c | harge for |
| • | I hereby auth | norize the release to the Deputy I | Registrar any documents in the custody of country of the custody of country of the custody of th | | unsel relating to |
| • | | esults of this check indicate that course to verify any such criminal reco | a criminal record or outstanding charge ford. | for a relevant offence may exist, I ag | gree to provide |
| • | The Deputy F | Registrar will notify me and my o as been referred to the Deputy Re | rganization that I have an outstanding c | charge or conviction for any relevant | offence(s) and |
| • | The Deputy R | Registrar will determine whether o | r not I present a risk to physical or sexua | al abuse to children. | |
| • | The Deputy F I have receive | - | isclosed to my organization and it will inc | clude consideration of any relevant o | ffence for which |
| • | agree to repo | | offence at any time subsequent to the croorganization and provide my organization | | • |
| | "Deputy Regist | trar" means a person appointed under th | he Public Service Act as deputy registrar for the p | purposes of this Act. | |
| | | | | | |
| | | and understood the Consent s as indicated by my signatur | for Release of Information and Ack | nowledgements above. I hereby | consent to |
| | | | acists of British Columbia to conduct y withdraw this consent for future c | | ngoing basis |
| | | | | | |
| | | | | | |
| | | | | | |

Applicant signature

Date



Page 1 of 3



NON-PRACTISING PHARMACY TECHNICIAN REGISTRATION

APPLICATION FOR

| APPLICANT INFORMATION | | | | | | | | | | | | | | | | | | |
|-----------------------|--------------|--------|--------|------------|---------|---------|---------|---------|----------|---------|----------|---------|---------------|----------|--------|-------------|-------|--|
| | ☐ Ms | | Mrs | | Miss | | Mr | [| п | Or | | Reg # | <u> </u> | | | | | |
| Name | Last name | (Surna | me) | | | | First n | ame | | | | Other r | ame(s) | | | | | |
| Address | | | | | | | | | | | | Tel (ho | | | | | | |
| | | | | | | | | | | | | Tel (wo | ork) | | | | | |
| | | | | | | | | | | | | Email | | | | | | |
| | City | | | | | | Provin | се | | | | | | | | | | |
| | Postal code | 2 | | | | | Counti | ry | | | | | | | | | | |
| | | | | | | | DAY | VME | NT | ODTI | NN | | | | | | | |
| | | | | | | | PA | YME | INI | OPTIC | /N | | | | | | | |
| □ Chequ | ue/Money | order | (p. | ayable to | College | of Pha | ırmacis | ts of E | BC) | | | | | | | | | |
| □ VISA | | l Ma | asterC | ard | | | | | | | | | D | | | 226 | 00 | |
| Card # | | | | | | | | < | | Exp _ | | | GST | ation fe | e _ | 336. 16. | | |
| Cardholder | name | | | | | | | | | V | | | Total | | _ | \$352. | 80 | |
| Cardholder s | | | | | | | | | | | | | | G | SST # | R106953 | 920 | |
| | 3 | | | | | N | | | | | | L | | | | | | |
| | | | | | | | | | 7 | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| I attest that | | | | | | | | | | | | | | | | | | |
| Pharmacists | Regulation | n and | the B | ylaws | of the | e Coll | lege | of Pl | harn | nacists | of Briti | sh Colu | mbia made | pursua | int to | these | Acts. | |
| I have signe | d and atta | ched | | | 1 | | | | | | | | | | | | | |
| | Statutory De | | | se form o | n page | 2). | | | | | | | | | | | | |
| | Criminal Rec | ord Ch | eck Au | thorizatio | on (ι | ise for | m on p | page . | 3). | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| | | Date | | | | | | | | | | | icant signatı | | | | | |



APPLICATION FOR

Statutory Declaration (Form 5)

NON-PRACTISING PHARMACY TECHNICIAN REGISTRATION

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 dec | lare | the facts set out herein to be true. |
| | | Date Applicant signature |



APPLICATION FOR

NON-PRACTISING PHARMACY TECHNICIAN REGISTRATION

Criminal Record Check Authorization

| | | | APPLICANT INFORMATION | ON | |
|-------|--------------------------------|---|---|--|---------------------------------------|
| Log | al name | | | | |
| _ | | Last name (Surname) | First name | Other name(s) | |
| Ман | ling address | Street | City/town | Province/State | Postal Code |
| | | Country | Contact pho | Area code | |
| Gen | der | □ Male □ Female E | B.C. Driver License | | |
| Birtl | h date | E | sirthplace | | |
| Oth | er names use | /YYY-MM-DD d or have used <i>(e.g. maiden na</i> | City/town me, birth name, previous married name) | Province/State | Country |
| Oth | | a of flave asea (e.g. maidel ha | me, bitar name, previous married name, | | |
| | 1. | Surname | First name | Mid ale n ame | |
| | 2. | Surname | First name | Middle name | |
| | 3. | Surname | First name | Middle name | · · · · · · · · · · · · · · · · · · · |
| | | | | | |
| | | FREEDOM OF INFOR | RMATION AND PROTECTION | OF PRIVACY ACT (FOIPPA) | |
| | | | under the authority of the Criminal Rechich govern both these acts. The inform | | |
| | | | criminal records information and is in co | | |
| | | CONSENT FOR RE | LEASE OF INFORMATION ANI | D ACKNOWLEDGEMENTS | |
| | | Pursua | nt to the B.C. Criminal Record | ds Review Act | |
| | I hereby cons | cent to a check for records of cri | minal convictions to determine whether | I have a conviction or outstanding ch | arge for |
| • | | offences under the Criminal Rec | | Thave a conviction of outstanding the | arge for |
| • | | | Registrar any documents in the custor elevant offence as defined under the Cri | | counsel relating to |
| • | | sults of this check indicate that its to verify any such criminal re | a criminal record or outstanding charge cord. | ge for a relevant offence may exist, I | agree to provide |
| • | | Registrar will notify me and my as been referred to the Deputy F | organization that I have an outstandin | g charge or conviction for any relevan | nt offence(s) and |
| • | | | or not I present a risk to physical or se | xual abuse to children. | |
| • | The Deputy F I have receive | | disclosed to my organization and it will | include consideration of any relevant | offence for which |
| • | agree to repo | | nt offence at any time subsequent to th y organization and provide my organiza | | |
| | "Deputy Regist | rar" means a person appointed under | the Public Service Act as deputy registrar for | the purposes of this Act. | |
| | | | | | |
| | | and understood the Consers as indicated by my signatu | nt for Release of Information and <i>F</i> ire below. | Acknowledgements above. I hereb | by consent to |
| | | | nacists of British Columbia to cond ay withdraw this consent for futur | | ongoing basis |
| | | | | | |
| | | Date | | Applicant signature | |

PHARMACIST REGISTRATION RENEWAL



eServices ID

Dear,

REGISTRATION EXPIRY:

For your upcoming renewal, we are pleased to enclose your registration renewal package:

Registration & payment option
 Profile update – contact & education information
 Profile update – employment information
 Statutory & insurance declaration

Pages 1 to 4 must be completed, signed, and returned with payment to the College office on or before midnight of the expiry date. If your employer pays your fee, you must submit page 1 to your employer for inclusion with their payment and return pages 2 - 4.

For your convenience, online renewal is available by *eServices* on the college website (see back of page 1 for more information).

Important Note: PDAP's CE Requirement tied to Registration Renewal

You must complete the Continuing Education (CE) component of the College's Professional Development and Assessment Program (PDAP) in order to maintain your eligibility to renew. Further details regarding this requirement are available by logging into eServices from the College website (www.bcpharmacists.org) and selecting PDAP from the main menu.

over >>>

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PHARMACIST REGISTRATION RENEWAL

Cont...

Non-Practising Registration Category (HPA bylaw, section 48)

To transfer to this category, select "Non-Practising Pharmacist" registration option on page 1. You will need to complete, sign and return the full renewal package including the criminal record check authorization. You will not need professional liability insurance.

Former Category

To transfer to this category, select the "Former Pharmacist" option, sign, and return page 1. You will <u>not</u> need to complete or return pages 2 to 4. However, if there are changes to your contact information, update and return page 2.

If you have any questions or comments, please feel free to contact:

Doris Wong
Administrative Assistant – Renewals & Records
(604) 676-4224 or doris.wong@bcpharmacists.org

Yours truly,

Registrar

To protect the public by ensuring that College registrants provide safe and effective pharmacy care to help people achieve better health.





PHARMACIST REGISTRATION RENEWAL

| Reg # | expires | |
|-------|---------|--|
| | | |
| | | |

eServices ID

| REGISTRATION O | PTION FOR | NEXT YEAR |
|----------------|-----------|------------------|
|----------------|-----------|------------------|

| REGISTRATION OF | 1101110 | K NEXT TE | | |
|---|---------------|-----------------------|------------------|------------------|
| Registration option (select only one option) | FEE | GST | TOTAL | |
| ☐ Full pharmacist (years 1 to 5) | \$682.50 | + \$34.13 = \$ | 716.63 | |
| ☐ Full pharmacist (years 6+) | \$630.00 | + \$31,50 = \$ | 661.50 | |
| □ Non-practising pharmacist | | + \$25.20 = \$ | • | |
| ☐ Former pharmacist (with newsletter) | | + \$ 5.25 = \$ | | |
| ☐ Former pharmacist (without newsletter) | \$0.00 | | | |
| | | | | |
| | | | \$ | |
| | | | т | |
| | | • | | |
| | | | | ¢ |
| | | | TOTAL | \$ |
| | | | | GST # R106953920 |
| | | | | |
| | oper | N | | |
| PAYME | NT OPTIC | ON | | |
| ☐ Cheque/Money order (payable to College of | . Dharmasista | of BC) | | |
| | Pnarmacists (| or BC) | | |
| □ VISA □ MasterCard | | | | |
| Card # | | Exp/_ | | |
| | | | | |
| Cardholder name | | | | |
| Cardholder signature | | | | |
| | | | | |
| | | | | |
| | | | | |
| I attest that I am in compliance with the Health Pro-Act, the Pharmacists Regulation and the Bylaws of t to these Acts. | | | | |
| | | | | |
| | | | | |
| | | Penis | strant signature | |

ONLINE RENEWAL

Go to <u>www.bcpharmacists.org</u> > eServices

Three easy and convenient ways to renew and/or pay online

1. Complete your renewal <u>online</u> and pay by credit card <u>online</u>:

- Go to <u>www.bcpharmacists.org</u> > eServices and follow the prompts to log-on and to complete your renewal and payment.
- You do not have to return any renewal documents to the college office.

2. Complete your renewal online and pay by cheque or credit card:

- Go to <u>www.bcpharmacists.org</u> > <u>eServices</u> and follow the prompts to log-on and to complete your renewal.
- Complete and sign page 1 of the renewal package. Mail this page together with your cheque or credit card information to the college office.
- You do not have to return pages 2-5.

3. Complete your renewal online and your employer pays:

- Go to <u>www.bcpharmacists.org</u> > eServices and follow the prompts to log-on and to complete your renewal.
- Complete and sign page 1 of the renewal package. Give this page to your employer for inclusion with their cheque.
- You do not have to return pages 2-5.



PHARMACIST REGISTRATION RENEWAL

Profile Update

You must immediately notify the College office of any changes to your contact information, employment information, and any other registration information previously provided (HPA bylaw, section 54).

eServices ID

| CONTACT INFORMATION | | | | | | | | |
|---------------------|----------------|----------------|-------------------------------|--|--|--|--|--|
| | CURRENT INFOR | MATION | UPDATE IF NECESSARY | | | | | |
| Send mail to my * | ■ home address | □ work address | □ home address □ work address | | | | | |
| Mailing address * | | | | | | | | |
| | | | Address 1 | | | | | |
| | | | Address 2 | | | | | |
| | | | City | | | | | |
| | | | Postal code Country | | | | | |
| Email * | | | | | | | | |
| Tel (Home) * | | | | | | | | |
| Tel (Work) | | | | | | | | |
| , | | | | | | | | |
| * denotes require | ed information | | | | | | | |
| | | | | | | | | |
| | | EDUC | CATION | | | | | |

| Diploma Baccalaurea University Graduation year | ee | □ PharmD | | | | | |
|--|-----------------|---------------------|--|--|--|--|--|
| | | | | | | | |
| Province/State Country | | | | | | | |
| Highest post-basic education in pharmacy Baccalaureate Masters Department Doctorate | | | | | | | |
| ☐ Accredited residency - Hospital | ☐ Accredited re | sidency - Community | | | | | |
| University | | | | | | | |
| Graduation year | | | | | | | |
| Province/State Country | | | | | | | |

If changes are made in this section, you must submit supporting documents (e.g. copy of degree or completion certificate).





Profile Update

eServices ID

| ΕМ | P | LO | ΥI | М | 且 | ľ | Ī |
|----|---|----|----|---|---|---|---|
|----|---|----|----|---|---|---|---|

| EMPLOYMENT STATUS: | A. Employed in the profession of pharmacy (provide details below) |
|--------------------|--|
| | B. Employed in other than the profession of pharmacy, seeking employment in the profession of pharmacy |
| | C. Employed in other than the profession of pharmacy, not seeking employment in the profession of pharmacy |
| | D. Unemployed and seeking employment in the profession of pharmacy |
| | E. Unemployed and not seeking employment in the profession of pharmacy |
| | |

| Primary Pharmacare # | Secondary Pharmacare # | Third Pharmacare # | | |
|--|--|--|--|--|
| | | | | |
| Employer name | Employer name | Employer name | | |
| | | | | |
| Prov Postal code | Prov Postal code | Prov Postal code | | |
| Country | Country | Country | | |
| , | | | | |
| CATEGORY: | CATEGORY: | CATEGORY: | | |
| ☐ Permanent employee | ☐ Permanent employee | ☐ Permanent employee | | |
| Casual employee | ☐ Casual employee | Casual employee | | |
| ☐ Temporary employee | ☐ Temporary employee | ☐ Temporary employee | | |
| ☐ Self employed | ☐ Self employed | ☐ Self employed | | |
| POSITION: | POSITION: | POSITION: | | |
| ☐ Director of Pharmacy | ☐ Director of Pharmacy | ☐ Director of Pharmacy | | |
| ☐ Pharmacy Owner/Manager | ☐ Pharmacy Owner/Manager | ☐ Pharmacy Owner/Manager | | |
| ☐ Pharmacy Manager | ☐ Pharmacy Manager | ☐ Pharmacy Manager | | |
| ☐ Researcher | Researcher | ☐ Researcher | | |
| ☐ Staff Pharmacist | ☐ Staff Pharmacist | ☐ Staff Pharmacist | | |
| ☐ Pharmacist Consultant | ☐ Pharmacist Consultant | Pharmacist Consultant | | |
| Educator | ☐ Educator | Educator | | |
| ☐ Industrial Pharmacist | Industrial Pharmacist | ☐ Industrial Pharmacist | | |
| ☐ Institutional Leader/Coordinator | ☐ Institutional Leader/Coordinator | ☐ Institutional Leader/Coordinator | | |
| ☐ Other | □øther | ☐ Other | | |
| WEEKLY PRACTICE HOURS: | WEEKLY PRACTICE HOURS: | WEEKLY PRACTICE HOURS: | | |
| ☐ 40 and above ☐ 15 - 29 | ☐ 40 and above ☐ 15 - 29 | ☐ 40 and above ☐ 15 - 29 | | |
| ☐ 30 - 39 ☐ 14 or less | ☐ 30 - 39 ☐ 14 or less | ☐ 30 - 39 ☐ 14 or less | | |
| | | | | |
| PLACE OF EMPLOYMENT: | PLACE OF EMPLOYMENT: | PLACE OF EMPLOYMENT: | | |
| \square Hospital and other health care facilities | ☐ Hospital and other health care facilities | \square Hospital and other health care facilities | | |
| Community pharmacy | ☐ Community pharmacy | ☐ Community pharmacy | | |
| ☐ Other pharmacy | ☐ Other pharmacy | ☐ Other pharmacy | | |
| ☐ Group professional practice/clinic | ☐ Group professional practice/clinic | ☐ Group professional practice/clinic | | |
| ☐ Community health centre | ☐ Community health centre | ☐ Community health centre | | |
| ☐ Other community-based pharmacist practice | ☐ Other community-based pharmacist practice | ☐ Other community-based pharmacist practice | | |
| ☐ Post-secondary educational institution | ☐ Post-secondary educational institution | ☐ Post-secondary educational institution | | |
| \square Association/government/para-governmental | ☐ Association/government/para-governmental | ☐ Association/government/para-governmental | | |
| \square Health-related industry/manufacturing/commercial | ☐ Health-related industry/manufacturing/commercial | \square Health-related industry/manufacturing/commercial | | |
| ☐ Community pharmacy corporate office | ☐ Community pharmacy corporate office | ☐ Community pharmacy corporate office | | |
| ☐ Other | ☐ Other | ☐ Other | | |
| 1 | 1 | | | |

PHARMACIST REGISTRATION RENEWAL



Statutory & Insurance Declaration

eServices ID

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

| Ι, _ | | 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. |
| | Γ | a charge relating to an offense under any Act regulating the practice of pharmacy or relating to the sale of drugs, or relating to any criminal offense; a finding of guilt in relation to an offense under any Act regulating the practice of pharmacy or 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 are not true (i.e. if any of the above boxes are 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. |
| | | PROFESSIONAL LIABILITY INSURANCE |
| | | I have professional liability insurance that meets the following criteria: Provides a minimum of \$2 million coverage. Provides occurrence based coverage or claims made with extended reporting period of at least 3 years. If not in the pharmacists' name, the group policy covers the pharmacist as an individual. Not applicable to me (I am currently in Non-Practising pharmacist category). |
| | I de | eclare the facts set out herein to be true. |

Applicant signature

Date





eServices ID

.

Dear,

REGISTRATION EXPIRY:

For your upcoming renewal, we are pleased to enclose your registration renewal package:

Registration & payment option
 Profile update - contact & education information
 Profile update - employment information
 Statutory & insurance declaration

Pages 1 to 4 must be completed, signed, and returned with payment to the College office on or before midnight of the expiry date. If your employer pays your fee, you must submit page 1 to your employer for inclusion with their payment and return pages 2 - 4.

IMPORTANT - TIMELY RESPONSE REQUIRED:

Please be advised that failure for the College to receive your completed renewal package, including payment, on or before your registration expiry date will result in an automated transfer of your status on the College register from 'active' to 'inactive' (HPA Bylaw 51(5)).

There are a number of significant and immediate consequences as a result of this including the cancellation of your access to PharmaNet, which could take up to two business days to reactivate, and the potential that your liability insurance would be null and void. In addition you will be subject to the current late registration and reinstatement fee of \$131.25 plus applicable taxes (HPA Bylaw 53(d)).

over >>>



Cont...

Former Category

To transfer to this category, select the "Former Pharmacist" option, sign, and return page 1. You will <u>not</u> need to complete or return pages 2 to 4. However, if there are changes to your contact information, update and return page 2.

If you have any questions or comments, please feel free to contact:

Doris Wong
Administrative Assistant – Records
(604) 676-4224 or doris.wong@bcpharmacists.org

Yours truly,

Registrar

To protect the public by ensuring British Columbia pharmacists provide safe and effective pharmacy care to help people achieve better health.



Reg #

expires

Card #

Cardholder name

Cardholder signature _

LIMITED PHARMACIST REGISTRATION RENEWAL

| | eServices ID |
|--|------------------|
| | |
| REGISTRATION OPTION FOR NEXT YEAR | |
| Registration option (select only one option) FEE GST TOTAL | • |
| ☐ Limited pharmacist $$682.50 + $34.13 = 716.63 | |
| | |
| | |
| | \$ |
| | |
| | \$ |
| | \$ |
| TOTAL | \$ |
| | GST # R106953920 |
| PAYMENT OPTION | |
| PATRIENT OF FIGH | |
| ☐ Cheque/Noney order (payable to College of Pharmacists of BC) | |
| □ VISA □ MasterCard | |

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.

| Date | Registrant signature |
|------|----------------------|



Profile Update

You must immediately notify the College office of any changes to your contact information, employment information, and any other registration information previously provided (HPA bylaw, section 54).

eServices ID

| CONTACT INFORMATION | | | | | | | |
|---------------------|--------------------------------|----------------|-------------------------------|--|--|--|--|
| | CURRENT INFOR | MATION | UPDATE IF NECESSARY | | | | |
| Send mail to my * | ■ home address | □ work address | □ home address □ work address | | | | |
| Mailing address * | | | | | | | |
| | | | Address 1 | | | | |
| | | | Address 2 | | | | |
| | | | City | | | | |
| | | | Postal code Country | | | | |
| Email * | | | | | | | |
| Tel (Home) * | | | | | | | |
| Tel (Work) | | | | | | | |
| * denotes require | * denotes required information | | | | | | |
| | | EDUC | CATION | | | | |
| | | | | | | | |

| | E | Sasic education | n in pharmacy | |
|---|------------------|-----------------|----------------------|---|
| □ Diploma | ☐ Baccalaureate | ☐ Masters | p PharmD | |
| University Graduation year Province/State | Gountry | | | |
| | Highest | post-basic e | ducation in pharmacy | , |
| \square Baccalaureate | ☐ Masters | ☐ PharmD | ☐ Doctorate | |
| ☐ Accredited resi | dency - Hospital | ☐ Accredited r | esidency - Community | |
| | | | | |
| University | | | | |
| Graduation year | _ | | | |
| | | | | |
| Province/State | Country | | | |

If changes are made in this section, you must submit supporting documents (e.g. copy of degree or completion certificate).



Profile Update

eServices ID

EMPLOYMENT

| EMPLOYMENT STATUS: | Р | A. Employed in the profession of pharmacy (provide details below) |
|--------------------|---|--|
| | | B. Employed in other than the profession of pharmacy, seeking employment in the profession of pharmacy |
| | | C. Employed in other than the profession of pharmacy, not seeking employment in the profession of pharmacy |
| | | D. Unemployed and seeking employment in the profession of pharmacy |
| | | E. Unemployed and not seeking employment in the profession of pharmacy |

| Primary | Pharmacare # | Secondary | Pharmacare # | Third | Pharmacare # |
|-----------------------------|-------------------------------|-----------------------|-------------------------------|------------------------|------------------------------|
| | | | | | |
| | | | | | |
| Employer name | | Employer name | | Émployer name | |
| Prov | Postal code | Prov | Postal code | Prov | Postal code |
| FIOV | rostal code | FIOV | rostal code | | rostal code |
| Country | | Country | | Country | |
| | | | | | |
| CATEGORY: | | CATEGORY: | | CATEGORY: | |
| ☑ Permanent emplo | ivee | ☐ Permanent emplo | vee | ☐ Permanent employ | ree |
| ☐ Casual employee | ,,,,, | ☐ Casual employee | , ee | ☐ Casual employee | |
| ☐ Temporary emplo | yee | ☐ Temporary emplo | yee | ☐ Temporary employ | ee |
| ☐ Self employed | | ☐ Self employed | | ☐ Self employed | |
| | | | | | |
| POSITION: | | POSITION: | | POSITION: | |
| ☐ Director of Pharm | асу | ☐ Director of Pharm | асу | ☐ Director of Pharma | су |
| ☐ Pharmacy Owner/ | Manager | ☐ Pharmacy Owner | Manager | ☐ Pharmacy Owner/N | Manager |
| ☐ Pharmacy Manage | er | ☐ Pharmacy Manage | er | ☐ Pharmacy Manager | |
| ☐ Researcher | | ☐ Researcher | | ☐ Researcher | |
| ☐ Staff Pharmacist | | ☐ Staff Pharmacist | | ☐ Staff Pharmacist | |
| ☐ Pharmacist Consu | ltant | ☐ Pharmacist Consu | ltant | ☐ Pharmacist Consul | tant |
| | | ☐ Educator | | ☐ Educator | |
| ☐ Industrial Pharmacist | | ☐ Industrial Pharma | cist | ☐ Industrial Pharmac | tist |
| ☐ Institutional Lead | er/Coordinator | ☐ Institutional Lead | er/Coordinator | ☐ Institutional Leade | r/Coordinator |
| ☐ Other | | Other | | ☐ Other | |
| WEEKLY PRACTICE H | IOURS: | WEEKLY PRACTICE H | IOURS: | WEEKLY PRACTICE H | OURS: |
| ☐ 40 and above | □ 15 - 29 | ☐ 40 and above | □ 15 - 29 | ☐ 40 and above | □ 15 - 29 |
| ■ 40 and above ■ 30 - 39 | ☐ 15 - 29 | ☐ 40 and above | ☐ 15 - 29 ☐ 14 or less | ☐ 40 and above | ☐ 15 - 29 |
| 조 30 - 39 | ☐ 14 Of less | □ 30 - 39 | ☐ 14 or less | □ 30 - 39 | ☐ 14 or less |
| PLACE OF EMPLOYMI | ENT: | PLACE OF EMPLOYM | ENT: | PLACE OF EMPLOYME | NT: |
| ☑ Hospital and othe | r health care facilities | ☐ Hospital and othe | r health care facilities | ☐ Hospital and other | health care facilities |
| ☐ Community pharn | nacy | ☐ Community pharr | nacy | ☐ Community pharm | acy |
| ☐ Other pharmacy | | ☐ Other pharmacy | | ☐ Other pharmacy | |
| ☐ Group professiona | l practice/clinic | ☐ Group professiona | al practice/clinic | ☐ Group professional | practice/clinic |
| ☐ Community health | n centre | ☐ Community healtl | h centre | ☐ Community health | centre |
| ☐ Other community | -based pharmacist practice | ☐ Other community | -based pharmacist practice | ☐ Other community- | based pharmacist practice |
| ☐ Post-secondary ed | lucational institution | ☐ Post-secondary ed | ducational institution | ☐ Post-secondary ed | ucational institution |
| ☐ Association/gover | nment/para-governmental | ☐ Association/gover | nment/para-governmental | ☐ Association/govern | ment/para-governmental |
| ☐ Health-related indu | stry/manufacturing/commercial | ☐ Health-related indu | stry/manufacturing/commercial | ☐ Health-related indus | try/manufacturing/commercial |
| ☐ Community pharn | nacy corporate office | ☐ Community pharr | nacy corporate office | ☐ Community pharm | acy corporate office |
| ☐ Other | | ☐ Other | | ☐ Other | |
| | | l | | 1 | |



Statutory & Insurance Declaration

eServices ID

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

| Ι, | | 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 regulating the practice of pharmacy or relating to the sale of drugs, or relating to any criminal offense; a finding of guilt in relation to an offense under any Act regulating the practice of pharmacy or 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 are not true (i.e. if any of the above boxes are 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. |
| | | PROFESSIONAL LIABILITY INSURANCE |
| | | I have professional liability insurance that meets the following criteria: Provides a minimum of \$2 million coverage. Provides occurrence based coverage or claims made with extended reporting period of at least 3 years. If not in the pharmacists' name, the group policy covers the pharmacist as an individual. Not applicable to me (I am currently in Non-Practising pharmacist category). |
| | 1 4 | eclare the facts set out herein to be true. |
| | ı ue | cuate the facts set out herein to be tide. |
| | | |
| | _ | |

Applicant signature

Date



eServices ID

.

Dear,

REGISTRATION EXPIRY:

For your upcoming renewal, we are pleased to enclose your registration renewal package:

Registration & payment option p.1
 Profile update – contact & education information p.2
 Profile update – employment information p.3
 Statutory & insurance declaration p.4

Pages 1 to 4 must be completed, signed, and returned with payment to the College office on or before midnight of the expiry date. If your employer pays your fee, you must submit page 1 to your employer for inclusion with their payment and return pages 2-4.

Late Fee and Reinstatement (HPA bylaw, sections 52 and 53)

You will be subject to the terms of late fee and reinstatement if completed renewal package is not received before registration expiry.

Former Category

To transfer to this category, select the "Former Pharmacist" option, sign, and return page 1. You will not need to complete or return pages 2 to 4. However, if there are changes to your contact information, update and return page 2.

If you have any questions or comments, please feel free to contact:

Yours truly,

Registrar

To protect the public by ensuring that College registrants provide safe and effective pharmacy care to help people achieve better health.



| | | | Reg # expires |
|--|--|----------------------|-----------------|
| | | | |
| | | | eServices ID |
| REGISTRATION (| OPTION FOR NEXT YEAR | | |
| Registration option (select only one option) ☐ Non-practising pharmacist ☐ Former pharmacist (with newsletter) ☐ Former pharmacist (without newsletter) | \$ 504.00 + \$ 25.20 = \$ 105.00 + \$ 5.25 = \$ 0.00 | * 529.20 * 110.25 | \$ |
| | | TOTAL | \$ GST # R10 |
| ☐ Cheque/Money order (payable to College of | F Pharmacists of BC) | | |
| | Exp/ | _ | |
| Cardholder name | | _ | |
| Cardholder signature | | _ | |
| I attest that I am in compliance with the Health P Act, the Pharmacists Regulation and the Bylaws o to these Acts. | | | |
| | | | |



Profile Update

You must immediately notify the College office of any changes to your contact information, employment information, and any other registration information previously provided (HPA bylaw, section 54).

eServices ID

| CONTACT INFORMATION | | | | | | | |
|---------------------|--------------------------------|----------------|-----------------------|----------------|--|--|--|
| CURRENT INFORMATION | | | UPDATE IF NECESSARY | | | | |
| Send mail to my * | home address | □ work address | ☐ home address | □ work address | | | |
| Mailing address * | | | | | | | |
| | | | Address 1 | | | | |
| | | | Address 2 | | | | |
| | | | City | Province | | | |
| | | | Postal code | Country | | | |
| Email * | | | | | | | |
| Tel (Home) * | | | | | | | |
| Tel (Work) | | | | | | | |
| * denotes requ | * denotes required information | | | | | | |
| | | EDU | CATION | | | | |
| | | | | | | | |

| ☐ Diploma University Graduation year | □ Baccalaureate | ☐ Masters | ☐ PharmD |
|--|---------------------|-------------------------|---------------------|
| | | | |
| Province/State | Jountry | | |
| □ Baccalaureate | Highest | post-basic ed □ PharmD | ucation in pharmacy |
| ☐ Accredited reside | sidency - Community | | |
| University | | | |
| Graduation year | | | |
| | | | |

If changes are made in this section, you must submit supporting documents (e.g. copy of degree or completion certificate).



Profile Update

eServices ID

EMPLOYMENT

| | EM COTMENT |
|--------------------|--|
| | |
| EMPLOYMENT STATUS: | A. Employed in the profession of pharmacy (provide details below) |
| | B. Employed in other than the profession of pharmacy, seeking employment in the profession of pharmacy |
| | C. Employed in other than the profession of pharmacy, not seeking employment in the profession of pharmacy |
| | D. Unemployed and seeking employment in the profession of pharmacy |
| | E. Unemployed and not seeking employment in the profession of pharmacy |
| | |

| Pharmacare # | Secondary Pharmacare # | Third Pharmacare # | |
|--|--|--|--|
| | | | |
| | | | |
| Employer name | Employer name | Employer name | |
| | | | |
| Prov Postal code | Prov Postal code | Prov Postal code | |
| Country | Country | Country | |
| Country | Country | Country | |
| CATEGORY: | CATEGORY: | CATEGORY: | |
| CATEGORY | CATEGORY | CATEGORY | |
| ☐ Permanent employee | ☐ Permanent employee | ☐ Permanent employee | |
| ☐ Casual employee | ☐ Casual employee | ☐ Casual employee | |
| ☐ Temporary employee | ☐ Temporary employee | ☐ Temporary employee | |
| ☐ Self employed | ☐ Self employed | ☐ Self employed | |
| | | | |
| POSITION: | POSITION: | POSITION: | |
| ☐ Director of Pharmacy | ☐ Director of Pharmacy | ☐ Director of Pharmacy | |
| ☐ Pharmacy Owner/Manager | ☐ Pharmacy Owner/Manager | ☐ Pharmacy Owner/Manager | |
| ☐ Pharmacy Manager | ☐ Pharmacy Manager | ☐ Pharmacy Manager | |
| Researcher | Researcher | Researcher | |
| ☐ Staff Pharmacist | ☐ Staff Pharmacist | ☐ Staff Pharmacist | |
| ☐ Pharmacist Consultant | ☐ Pharmacist Consultant | ☐ Pharmacist Consultant | |
| ☐ Educator | ☐ Educator | ☐ Educator | |
| ☐ Industrial Pharmacist | ☐ Industrial Pharmacist | ☐ Industrial Pharmacist | |
| ☐ Institutional Leader/Coordinator | ☐ Institutional Leader/Coordinator | ☐ Institutional Leader/Coordinator | |
| ☐ Other | Other | ☐ Other | |
| | - | | |
| WEEKLY PRACTICE HOURS: | WEEKLY PRACTICE HOURS: | WEEKLY PRACTICE HOURS: | |
| ☐ 40 and above ☐ 15 - 29 | ☐ 40 and above ☐ 15 - 29 | ☐ 40 and above ☐ 15 - 29 | |
| □ 30 - 39 □ 14 or less | ☐ 30 - 39 ☐ 14 or less | ☐ 30 - 39 ☐ 14 or less | |
| | | | |
| PLACE OF EMPLOYMENT: | PLACE OF EMPLOYMENT: | PLACE OF EMPLOYMENT: | |
| ☐ Hospital and other health care facilities | ☐ Hospital and other health care facilities | ☐ Hospital and other health care facilities | |
| ☐ Community pharmacy | ☐ Community pharmacy | ☐ Community pharmacy | |
| ☐ Other pharmacy | ☐ Other pharmacy | ☐ Other pharmacy | |
| ☐ Group professional practice/clinic | ☐ Group professional practice/clinic | ☐ Group professional practice/clinic | |
| ☐ Community health centre | ☐ Community health centre | ☐ Community health centre | |
| ☐ Other community-based pharmacist practice | ☐ Other community-based pharmacist practice | ☐ Other community-based pharmacist practice | |
| ☐ Post-secondary educational institution | ☐ Post-secondary educational institution | ☐ Post-secondary educational institution | |
| ☐ Association/government/para-governmental | ☐ Association/government/para-governmental | ☐ Association/government/para-governmental | |
| ☐ Health-related industry/manufacturing/commercial | ☐ Health-related industry/manufacturing/commercial | ☐ Health-related industry/manufacturing/commercial | |
| ☐ Community pharmacy corporate office | ☐ Community pharmacy corporate office | ☐ Community pharmacy corporate office | |
| ☐ Other | ☐ Other | ☐ Other | |
| | I . | I . | |



Statutory & Insurance Declaration

eServices ID

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

| Ι, _ | | 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 regulating the practice of pharmacy or relating to the sale of drugs, or relating to any criminal offense; a finding of guilt in relation to an offense under any Act regulating the practice of pharmacy or 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 are not true (i.e. if any of the above boxes are 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. |
| | | PROFESSIONAL LIABILITY INSURANCE |
| | ò | I have professional liability insurance that meets the following criteria: Provides a minimum of \$2 million coverage. Provides occurrence based coverage or claims made with extended reporting period of at least 3 years. If not in the pharmacists' name, the group policy covers the pharmacist as an individual. Not applicable to me (I am currently in Non-Practising pharmacist category). |
| | I de | eclare the facts set out herein to be true. |

Applicant signature

Date

40

UBC STUDENT REGISTRATION RENEWAL

eServices ID

Dear

REGISTRATION EXPIRY:

Please be advised your registration is up for renewal. The online process is automated, updated in real time and available 24/7, resulting in reduced resource requirements and increased efficiency for the College and its registrants. Your upcoming renewal must be completed online by following the steps below.

- 1. Go to www.bcpharmacists.org
- 2. Select eServices and follow prompts to login (NOTE: Your eServices ID is shown above)
- 3. Select Renew Registration
- 4. Follow the prompts to complete your renewal

The full renewal process, including payment, must be completed and received by the College on or before midnight of your expiry date. If you have any questions or comments, please feel free to contact:

Doris Wong
Administrative Assistant - Renewals & Records
(604) 676-4224 or doris.wong@bcpharmacists.org

Yours truly,

IMPORTANT - TIMELY RESPONSE REQUIRED:

Please be advised that failure for the College to receive your completed renewal package, including payment, on or before your registration expiry date will result in an automated transfer of your status on the College register from 'active' to 'inactive' (HPA Bylaw 51(5)). In addition, you will be subject to the current late registration and reinstatement fee of \$52.50 plus applicable taxes (HPA Bylaw 53(d)).



| Reg # | expires | |
|-------|---------|--|
| | | |

eServices II

| REGISTRATION | OPTION FOR NEXT | YEAR | |
|--|------------------------------------|-------------|----------------|
| Registration option (select only one option) | FEE GST | TOTAL | |
| ☐ UBC student pharmacist | \$52.50 + \$2.6 | 3 = \$55.13 | |
| | | \$ | |
| | | TOTAL | \$ GST # R1 |
| PAYM ☐ Cheque/Money order (payable to College | IENT OPTION of Pharmacists of BC) | | |
| □ VISA □ MasterCard | | | |
| Card # | Exp | | |
| Cardholder name | | | |
| | | | |

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.

| Date | Registrant signature |
|------|----------------------|



Profile Update

You must immediately notify the College office of any changes to your contact information, employment information, and any other registration information previously provided (HPA bylaw, section 54).

eServices ID

| CONTACT INFORMATION | | | | | |
|---------------------|----------------|----------------|-----------------------|----------------|--|
| | CURRENT INFOR | MATION | UPDATE IF NECES | SSARY | |
| Send mail to my * | ■ home address | □ work address | □ home address | □ work address | |
| Mailing address * | | | | | |
| | | | Address 1 | | |
| | | | Address 2 | | |
| | | | City | Province | |
| | | | Postal code | Country | |
| Email * | | | | | |
| Tel (Home) * | | | | | |
| Tel (Work) | | | | | |
| * denotes require | ed information | | | | |
| | | EDU | CATION | | |
| | | | | | |

| Diploma Baccalaurea University Graduation year | ee | □ PharmD |
|--|-------------------------------|---------------------|
| | | |
| Province/State Country | | |
| Highe | est post-basic ed □ PharmD | ucation in pharmacy |
| ☐ Accredited residency - Hospital | ☐ Accredited re | sidency - Community |
| University | | |
| Graduation year | | |
| Province/State Country | | |

If changes are made in this section, you must submit supporting documents (e.g. copy of degree or completion certificate).



Profile Update

eServices ID

| EΜ | PΙ | LO' | YΜ | 且 | NT |
|----|----|-----|----|---|----|
|----|----|-----|----|---|----|

| | 2.11.20.11.2111 |
|--------------------|--|
| | |
| EMPLOYMENT STATUS: | A. Employed in the profession of pharmacy (provide details below) |
| | B. Employed in other than the profession of pharmacy, seeking employment in the profession of pharmacy |
| | C. Employed in other than the profession of pharmacy, not seeking employment in the profession of pharmacy |
| | D. Unemployed and seeking employment in the profession of pharmacy |
| | E. Unemployed and not seeking employment in the profession of pharmacy |
| | |

| Pharmacare # | Secondary Pharmacare # | Third Pharmacare # | |
|---|--|---|--|
| | | | |
| | | | |
| Employer name | Employer name | Employer name | |
| | | | |
| Prov Postal code | Prov Postal code | Prov Postal code | |
| Country | Country | Country | |
| Country | Country | Country | |
| CATEGORY: | CATEGORY: | CATEGORY: | |
| CATEGORY: | CATEGORY: | CATEGORY: | |
| ☐ Permanent employee | ☐ Permanent employee | ☐ Permanent employee | |
| ☐ Casual employee | ☐ Casual employee | ☐ Casual employee | |
| ☐ Temporary employee | ☐ Temporary employee | ☐ Temporary employee | |
| ☐ Self employed | ☐ Self employed | ☐ Self employed | |
| | | | |
| POSITION: | POSITION: | POSITION: | |
| ☐ Director of Pharmacy | ☐ Director of Pharmacy | ☐ Director of Pharmacy | |
| ☐ Pharmacy Owner/Manager | ☐ Pharmacy Owner/Manager | ☐ Pharmacy Owner/Manager | |
| ☐ Pharmacy Manager | ☐ Pharmacy Manager | ☐ Pharmacy Manager | |
| Researcher | Researcher | Researcher | |
| ☐ Staff Pharmacist | ☐ Staff Pharmacist | ☐ Staff Pharmacist | |
| ☐ Pharmacist Consultant | ☐ Pharmacist Consultant | ☐ Pharmacist Consultant | |
| ☐ Educator | ☐ Educator | ☐ Educator | |
| ☐ Industrial Pharmacist | ☐ Industrial Pharmacist | ☐ Industrial Pharmacist | |
| ☐ Institutional Leader/Coordinator | Institutional Leader/Coordinator | ☐ Institutional Leader/Coordinator | |
| ☐ Other | Other | ☐ Other | |
| | | | |
| WEEKLY PRACTICE HOURS: | WEEKLY PRACTICE HOURS: | WEEKLY PRACTICE HOURS: | |
| ☐ 40 and above ☐ 15 - 29 | ☐ 40 and above ☐ 15 - 29 | ☐ 40 and above ☐ 15 - 29 | |
| □ 30 - 39 □ 14 or less | □ 30 - 39 □ 14 or less | ☐ 30 - 39 ☐ 14 or less | |
| | | | |
| PLACE OF EMPLOYMENT: | PLACE OF EMPLOYMENT: | PLACE OF EMPLOYMENT: | |
| ☐ Hospital and other health care facilities | ☐ Hospital and other health care facilities | ☐ Hospital and other health care facilities | |
| Community pharmacy | ☐ Community pharmacy | ☐ Community pharmacy | |
| Other pharmacy | ☐ Other pharmacy | ☐ Other pharmacy | |
| ☐ Group professional practice/clinic | ☐ Group professional practice/clinic | ☐ Group professional practice/clinic | |
| | ☐ Community health centre | ☐ Group professional practice/clinic ☐ Community health centre | |
| ☐ Community health centre ☐ Other community-based pharmacist practice | ☐ Other community-based pharmacist practice | ☐ Other community-based pharmacist practice | |
| ☐ Post-secondary educational institution | ☐ Post-secondary educational institution | ☐ Post-secondary educational institution | |
| ☐ Association/government/para-governmental | ☐ Association/government/para-governmental | ☐ Association/government/para-governmental | |
| ☐ Association/government/para-governmental ☐ Health-related industry/manufacturing/commercial | ☐ Health-related industry/manufacturing/commercial | ☐ Association/government/para-governmental ☐ Health-related industry/manufacturing/commercial | |
| | ☐ Community pharmacy corporate office | | |
| ☐ Community pharmacy corporate office ☐ Other | ☐ Community pnarmacy corporate office | ☐ Community pharmacy corporate office ☐ Other | |
| □ ouler | Li ottler | Li other | |



eServices ID

Statutory & Insurance Declaration

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 regulating the practice of pharmacy or relating to the sale of drugs, or relating to any criminal offense; a finding of guilt in relation to an offense under any Act regulating the practice of pharmacy or 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 are not true (i.e. if any of the above boxes are 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. |
| | <u> </u> | |
| | | PROFESSIONAL LIABILITY INSURANCE |
| | | I have professional liability insurance that meets the following criteria:Provides a minimum of \$2 million coverage. |
| | | Provides occurrence based coverage or claims made with extended reporting period of at least 3 years. If not in the pharmacists' name, the group policy covers the pharmacist as an individual. |
| | p | Not applicable to me (I am currently a UBC student pharmacist). |
| | | |
| | I de | eclare the facts set out herein to be true. |
| | | |
| | | |

Applicant signature

Date



eServices ID

,

Dear ,

REGISTRATION EXPIRY:

For your upcoming renewal, we are pleased to enclose your registration renewal package:

| • | Registration & payment option | p.1 |
|---|--|-----|
| • | Profile update – contact & education information | p.2 |
| • | Profile update – employment information | p.3 |
| • | Statutory & insurance declaration | p.4 |

Pages 1 to 4 must be completed, signed, and returned with payment to the College office on or before midnight of the expiry date. If your employer pays your fee, you must submit page 1 to your employer for inclusion with their payment and return pages 2 - 4.

For your convenience, online renewal is available by **eServices** on the college website (see back of page 1 for more information).

Important Note: PDAP's CE Requirement tied to Registration Renewal

You must complete the Continuing Education (CE) component of the College's Professional Development and Assessment Program (PDAP) in order to maintain your eligibility to renew. Further details regarding this requirement are available by logging into eServices from the College website (www.bcpharmacists.org) and selecting PDAP from the main menu.

over >>>





Cont...

Non-Practising Registration Category (HPA bylaw, section 48)

To transfer to this category, select "Non-Practising Pharmacy Technician" registration option on page 1. You will need to complete, sign and return the full renewal package. You will <u>not</u> need professional liability insurance.

Former Category

To transfer to this category, select the "Former Pharmacy Technician" option, sign, and return page 1. You will <u>not</u> need to complete or return pages 2 to 4. However, if there are changes to your contact information, update and return page 2.

If you have any questions or comments, please feel free to contact:

Yours truly,

Registrar

To protect the public by ensuring that College registrants provide safe and effective pharmacy care to help people achieve better health.





| Reg # | expires |
|-------|---------|
| | |
| | |

aSanvicas I

| Registration option (select only one op | otion) | FEE | GST | TOTAL | |
|---|-----------------------|-----------------------------|------------------|----------|----|
| ☐ Full pharmacy technician | | \$420.00 + | \$21.00 = | \$441.00 | |
| ☐ Non-practising pharmacy technicia | n | \$336.00 | \$16.80 = | \$352.80 | |
| ☐ Former pharmacy technician (with r | newsletter) | \$105.00 + | \$ 5.25 = | \$110.25 | |
| ☐ Former pharmacy technician (witho | ut newsletter) | \$ 0.00 | | | \$ |
| | | | | TOTAL | \$ |
| ☐ Cheque/Money order (paye | able to College of Ph | NT OPTION armacists of BC) | | | |
| □ VISA □ Master | ' | | | | |
| Card # | | Ex | p/ | _ | |
| Cardholder name | | | | _ | |
| Cardholder signature | | | | _ | |

Registrant signature

Date

ONLINE RENEWAL

Go to <u>www.bcpharmacists.org</u> > eServices

Three easy and convenient ways to renew and/or pay online

1. Complete your renewal online and pay by credit card online:

- Go to <u>www.bcpharmacists.org</u> > eServices and follow the prompts to log-on and to complete your renewal and payment.
- You do not have to return any renewal documents to the college office.

2. Complete your renewal online and pay by cheque or credit card:

- Go to <u>www.bcpharmacists.org</u> > eServices and follow the prompts to log-on and to complete your renewal.
- Complete and sign page 1 of the renewal package. Mail this page together with your cheque or credit card information to the college office.
- You do not have to return pages 2-4.

3. Complete your renewal online and your employer pays:

- Go to <u>www.bcpharmacists.org</u> > eServices and follow the prompts to log-on and to complete your renewal.
- Complete and sign page 1 of the renewal package. Give this page to your employer for inclusion with their cheque.
- You do not have to return pages 2-4.



PHARMACIST REGISTRATION RENEWAL

Profile Update

You must immediately notify the College office of any changes to your contact information, employment information, and any other registration information previously provided (HPA bylaw, section 54).

eServices ID

| | | CONTACT IN | FORMATION | | |
|-------------------|--------------------------------|----------------|---|--|--|
| | CURRENT INFORMA | ATION | UPDATE IF NECESSARY | | |
| Send mail to my * | ^ □ home address | □ work address | □ home address □ work address | | |
| Mailing address * | | | | | |
| | | | Address 1 | | |
| | | | Address 2 | | |
| | | | City | | |
| | | | Postal code Country | | |
| Email * | | | | | |
| Tel (Home) * | | | | | |
| Tel (Work) | | | | | |
| * | d information | | | | |
| * denotes require | d information | | | | |
| | | EDUC | ATION | | |
| | | | | | |
| | | Basic educati | on in pharmacy | | |
| ☐ Diplo | ma 🔲 Baccalai | reate | □ PharmD | | |
| Univo | | | | | |

If changes are made in this section, you must submit supporting documents (e.g. copy of degree or completion certificate).

PHARMACIST REGISTRATION RENEWAL



Profile Update

eServices ID

| ΕМ | | | |
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| EMPLOYMENT STATUS: | A. Employed in the profession of pharmacy (provide details below) |
|--------------------|--|
| | B. Employed in other than the profession of pharmacy, seeking employment in the profession of pharmacy |
| | C. Employed in other than the profession of pharmacy, not seeking employment in the profession of pharmacy |
| | D. Unemployed and seeking employment in the profession of pharmacy |
| | E. Unemployed and not seeking employment in the profession of pharmacy |
| | |

| Primary Pharmacare # | Secondary Pharmacare # | Third | | |
|--|--|--|--|--|
| | | | | |
| | | | | |
| Employer name | Employer name | Employer name | | |
| | | | | |
| Prov Postal code | Prov Postal code | Prov Postal code | | |
| Country | Country | Country | | |
| Country | Country | Couldy | | |
| CATEGORY: | CATEGORY: | CATEGORY: | | |
| | | | | |
| ☐ Permanent employee | Permanent employee | Permanent employee | | |
| ☐ Casual employee | ☐ Casual employee | ☐ Casual employee | | |
| ☐ Temporary employee | ☐ Temporary employee | ☐ Temporary employee | | |
| ☐ Self employed | ☐ Self employed | ☐ Self employed | | |
| POSITION: | POSITION: | POSITION: | | |
| ☐ Director of Pharmacy | ☐ Director of Pharmacy | ☐ Director of Pharmacy | | |
| ☐ Pharmacy Owner/Manager | ☐ Pharmacy Owner/Manager | ☐ Pharmacy Owner/Manager | | |
| ☐ Pharmacy Manager | ☐ Pharmacy Manager | ☐ Pharmacy Manager | | |
| Researcher | Researcher | Researcher | | |
| ☐ Staff Pharmacist | ☐ Staff Pharmacist | ☐ Staff Pharmacist | | |
| ☐ Pharmacist Consultant | ☐ Pharmacist Consultant | ☐ Pharmacist Consultant | | |
| □ Educator | ☐ Educator | □ Educator | | |
| ☐ Industrial Pharmacist | ☐ Industrial Pharmacist | ☐ Industrial Pharmacist | | |
| ☐ Institutional Leader/Coordinator | Institutional Leader/Coordinator | ☐ Institutional Leader/Coordinator | | |
| ☐ Other | □ Other | Other | | |
| E other | Дусты | 2 otte | | |
| WEEKLY PRACTICE HOURS: | WEEKLY PRACTICE HOURS: | WEEKLY PRACTICE HOURS: | | |
| ☐ 40 and above ☐ 15 - 29 | ☐ 40 and above ☐ 15 - 29 | ☐ 40 and above ☐ 15 - 29 | | |
| □ 30 - 39 □ 14 or less | □ 30 - 39 □ 14 or less | □ 30 - 39 □ 14 or less | | |
| | | | | |
| PLACE OF EMPLOYMENT: | PLACE OF EMPLOYMENT: | PLACE OF EMPLOYMENT: | | |
| ☐ Hospital and other health care facilities | ☐ Hospital and other health care facilities | ☐ Hospital and other health care facilities | | |
| ☐ Community pharmacy | ☐ Community pharmacy | ☐ Community pharmacy | | |
| ☐ Other pharmacy | ☐ Other pharmacy | ☐ Other pharmacy | | |
| ☐ Group professional practice/clinic | ☐ Group professional practice/clinic | ☐ Group professional practice/clinic | | |
| ☐ Community health centre | ☐ Community health centre | ☐ Community health centre | | |
| ☐ Other community-based pharmacist practice | ☐ Other community-based pharmacist practice | ☐ Other community-based pharmacist practice | | |
| ☐ Post-secondary educational institution | ☐ Post-secondary educational institution | □ Post-secondary educational institution | | |
| ☐ Association/government/para-governmental | ☐ Association/government/para-governmental | ☐ Association/government/para-governmental | | |
| ☐ Health-related industry/manufacturing/commercial | ☐ Health-related industry/manufacturing/commercial | ☐ Health-related industry/manufacturing/commercial | | |
| ☐ Community pharmacy corporate office | ☐ Community pharmacy corporate office | ☐ Community pharmacy corporate office | | |
| ☐ Other | ☐ Other | ☐ Other | | |
| | | | | |



Statutory & Insurance Declaration

eServices ID

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, | | |
|----|-------|---|
| | 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 disaplinary 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 Præissions 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 regulating the practice of pharmacy or relating to theale of drugs, or relating to any criminal offense; a finding of guilt in relation to an offense under any Act regulating the practice of pharmacy or 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 arenot true (i.e. if any of the above boxes arenot checked off). Details to include: a. Criminal offence/Disaplinary 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 have professional liability insurance that meets the following criteria: Provides a minimum of \$2 million coverage. Provides occurrence based coverage or claims made with extended reporting period of at least 3 years. If not in the pharmacists' name, the group policy covers the pharmacist as an individual. Not applicable to me (Iam currently in Non-Practising pharmacy technician category). |
| | T -1- | |
| | ı ae | clare the facts set out herein to be true. |
| | | |

 $Applicant\,signatu\,re$

Date



NON-PRACTISING PHARMACY TECHNICIAN REGISTRATION RENEWAL

eServices ID

Á

Dear,

REGISTRATION EXPIRY:

For your upcoming renewal, we are pleased to enclose your registration renewal package:

Registration & payment option p.1
 Profile update – contact & education information p.2
 Profile update – employment information p.3
 Statutory & insurance declaration p.4

Pages 1 to 4 must be completed, signed, and returned with payment to the College office on or before midnight of the expiry date. If your employer pays your fee, you must submit page 1 to your employer for inclusion with their payment and return pages 2-4.

Late Fee and Reinstatement (HPA bylaw, sections 52 and 53)

You will be subject to the terms of late fee and reinstatement if completed renewal package is not received before registration expiry.

Former Category

To transfer to this category, select the "Former Pharmacy Technician" option, sign, and return page 1. You want need to complete or return pages 2 to 4. However, if there are changes to your contact information, update and return page 2.

If you have any questions or comments, please feel free to contact:

Doris Wong
Administrative Assistant – Renewals & Records
(604) 676-4224 or doris.wong@bcpharmacists.org

Yours truly,

Registrar

To protect the public by ensuring that College registrants provide safe and effective pharmacy care to help people achieve better health.



NON-PRACTISING PHARMACY TECHNICIAN REGISTRATION RENEWAL $^{Page\ 1}$

| | Reg # expires |
|---|--------------------------------------|
| | |
| | |
| Á Á | |
| A | |
| | eServices ID |
| REGISTRATION OPTION FOR NE | XT YEAR |
| Registration option (select only one option) FEE | |
| Registration option (select only one option) □ Non-practising pharmacy technician \$336.00 + \$ | $\frac{\text{GST}}{16.80} = 352.80 |
| ☐ Former pharmacy technician (with newsletter) \$ 105.00 ← | \$5.25 = \$110.25 |
| ☐ Former pharmacy technician (without newsletter) \$ 0.00 | |
| | \$ |
| | • |
| | TOTAL \$ |
| | ŐST # R106953920 |
| | |
| | |
| PAYMENT OPTION | |
| | |
| ☐ Cheque/Money order (payable to College of Pharmacists of BC) | |
| □ VISA □ MasterCard | |
| Card # Exp | / |
| Cardholder name | |
| Cardholder signature | |
| | |
| | |
| I attest that I am in compliance with the Health Professions Act, the F Act, the Pharmacists Regulation and the Bylaws of the College of Pha | |
| to these Acts. | |
| | |
| | |
| Date | Registrant signature |



NON-PRACTISING PHARMACY TECHNICIAN REGISTRATION RENEWAL

Profile Update

You must immediately notify the College office of any changes to your contact information, employment information, and any other registration information previously provided (HPA bylaw, section 54).

eServices ID

| CONTACT INFORMATION | | | | | |
|---------------------|---------------------|----------------|-------------------------------|--|--|
| | CURRENT INFORMATION | | UPDATE IF NECESSARY | | |
| Send mail to my * | ■ home address | □ work address | □ home address □ work address | | |
| Mailing address * | | | | | |
| | | | Address 1 | | |
| | | | Address 2 | | |
| | | | City | | |
| | | | Postal code Country | | |
| Email * | | | | | |
| Tel (Home) * | | | | | |
| Tel (Work) | | | | | |
| * denotes require | ed information | | | | |
| | | FDI | ICATTON | | |

| | E | Basic education | ı in pharmacy | |
|---|-----------------|-----------------|---------------------------------|--|
| □ Diploma | ☐ Baccalaureate | ☐ Masters | □ PharmD | |
| University Graduation year Province/State | | | | |
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| □ Baccalaureate | | | ucation in pharmacy | |
| | ☐ Masters | ☐ PharmD | □ Doctorate sidency - Community | |
| ☐ Baccalaureate ☐ Accredited resid | ☐ Masters | ☐ PharmD | ☐ Doctorate | |
| ☐ Accredited resid | ☐ Masters | ☐ PharmD | ☐ Doctorate | |
| ☐ Accredited resid | ☐ Masters | ☐ PharmD | ☐ Doctorate | |

If changes are made in this section, you must submit supporting documents (e.g. copy of degree or completion certificate).



NON-PRACTISING PHARMACY TECHNICIAN REGISTRATION RENEWAL Page 3

Profile Update

eServices ID

| | EMPLOYMENT |
|-------------------|--|
| | |
| IPLOYMENT STATUS: | A. Employed in the profession of pharmacy (provide details below) |
| | B. Employed in other than the profession of pharmacy, seeking employment in the profession of pharmacy |
| | C. Employed in other than the profession of pharmacy, not seeking employment in the profession of pharmacy |
| | D. Unemployed and seeking employment in the profession of pharmacy |

 \square E. Unemployed and not seeking employment in the profession of pharmacy

| Primary Pharmacare # | Secondary Pharmacare # | Third Pharmacare # | |
|--|--|--|--|
| | | | |
| Employer name | Employer name | Employer name | |
| Prov Postal code | Prov Postal code | Prov Postal code | |
| | | | |
| Country | Country | Country | |
| CATEGORY: | CATEGORY: | CATEGORY: | |
| ☐ Permanent employee | ☐ Permanent employee | Permanent employee | |
| ☐ Casual employee | ☐ Casual employee | ☐ Casual employee | |
| ☐ Temporary employee | ☐ Temporary employee | ☐ Temporary employee | |
| ☐ Self employed | ☐ Self employed | ☐ Self employed | |
| | | | |
| POSITION: | POSITION: | POSITION: | |
| ☐ Director of Pharmacy | ☐ Director of Pharmacy | ☐ Director of Pharmacy | |
| ☐ Pharmacy Owner/Manager | ☐ Pharmacy Owner/Manager | ☐ Pharmacy Owner/Manager | |
| ☐ Pharmacy Manager | ☐ Pharmacy Manager | ☐ Pharmacy Manager | |
| Researcher | Researcher | ☐ Researcher | |
| ☐ Staff Pharmacist | ☐ Staff Pharmacist | ☐ Staff Pharmacist | |
| ☐ Pharmacist Consultant | ☐ Pharmacist Consultant | ☐ Pharmacist Consultant | |
| ☐ Educator | ☐ Educator | ☐ Educator | |
| ☐ Industrial Pharmacist | ☐ Industrial Pharmacist | ☐ Industrial Pharmacist | |
| ☐ Institutional Leader/Coordinator | ☐ Institutional Leader/Coordinator | ☐ Institutional Leader/Coordinator | |
| Other | Other | ☐ Other | |
| WEEKLY PRACTICE HOURS: | WEEKLY PRACTICE HOURS: | WEEKLY PRACTICE HOURS: | |
| ☐ 40 and above ☐ 15 - 29 | ☐ 40 and above ☐ 15 - 29 | \square 40 and above \square 15 - 29 | |
| □ 30 - 39 □ 14 or less | ☐ 30 - 39 ☐ 14 or less | □ 30 - 39 □ 14 or less | |
| | | | |
| PLACE OF EMPLOYMENT: | PLACE OF EMPLOYMENT: | PLACE OF EMPLOYMENT: | |
| ☐ Hospital and other health care facilities | ☐ Hospital and other health care facilities | ☐ Hospital and other health care facilities | |
| ☐ Community pharmacy | ☐ Community pharmacy | ☐ Community pharmacy | |
| ☐ Other pharmacy | ☐ Other pharmacy | ☐ Other pharmacy | |
| ☐ Group professional practice/clinic | ☐ Group professional practice/clinic | ☐ Group professional practice/clinic | |
| ☐ Community health centre | ☐ Community health centre | ☐ Community health centre | |
| \Box Other community-based pharmacist practice | ☐ Other community-based pharmacist practice | ☐ Other community-based pharmacist practice | |
| ☐ Post-secondary educational institution | ☐ Post-secondary educational institution | ☐ Post-secondary educational institution | |
| ☐ Association/government/para-governmental | ☐ Association/government/para-governmental | ☐ Association/government/para-governmental | |
| ☐ Health-related industry/manufacturing/commercial | ☐ Health-related industry/manufacturing/commercial | ☐ Health-related industry/manufacturing/commercial | |
| ☐ Community pharmacy corporate office | ☐ Community pharmacy corporate office | ☐ Community pharmacy corporate office | |
| ☐ Other | ☐ Other | ☐ Other | |
| | | | |



NON-PRACTISING PHARMACY TECHNICIAN REGISTRATION RENEWAL

Statutory & Insurance Declaration

eServices ID

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 regulating the practice of pharmacy or relating to the sale of drugs, or relating to any criminal offense; a finding of guilt in relation to an offense under any Act regulating the practice of pharmacy or 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 are not true (i.e. if any of the above boxes are 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. |
| | | PROFESSIONAL LIABILITY INSURANCE |
| | ė | I have professional liability insurance that meets the following criteria: Provides a minimum of \$2 million coverage. Provides occurrence based coverage or claims made with extended reporting period of at least 3 years. If not in the pharmacy technicians' name, the group policy covers the pharmacy technician as an individual. Not applicable to me (I am currently in Non-Practising pharmacy technician category). |
| | I de | eclare the facts set out herein to be true. |

Applicant signature

Date



Late Registration Renewal

□ Non-Practising Pharmacist□ Limited Pharmacist

☐ Full Pharmacist

| | | CONTACT INF | ORMATION | |
|--|--|------------------------------|--|---------------------|
| | | CONTACT IN | OKHATION | |
| | □ Ms □ Mrs | □ Miss □ Mr □ D | r | |
| Logal name | | | | |
| Legal name | Last name (Surname) | First name | Other name(s) | |
| Address | | | Tel (home) | |
| | | | T-4 12 | |
| | | | Tel (work) | |
| | City | Province | Email | |
| | City | Frovince | | |
| | Postal code | Country | | |
| | | | | |
| | | | | |
| | | PAYMENT | OPTION | |
| | | | ST LICE | |
| | | | | |
| | | | | |
| □ Cheque/I | Money order <i>(payable to C</i> | ollege of Pharmacists of BC) | Late resourch for 12 | 1.25 |
| □ Cheque/I | Money order <i>(payable to C</i> ☐ MasterCard | ollege of Pharmacists of BC) | | 1.25 6.56 |
| | | ollege of Pharmacists of BC) | | 6.56 |
| □ VISA Card # | □ MasterCard | ollege of Pharmacists of BC) | GST | 6.56 7.81 |
| □ VISA Card # Cardholder n | □ MasterCard | ollege of Pharmacists of BC) | | 6.56 7.81 |
| □ VISA Card # | □ MasterCard | ollege of Pharmacists of BC) | | 6.56 7.81 |
| □ VISA Card # Cardholder n | □ MasterCard | ollege of Pharmacists of BC) | | 6.56 7.81 |
| □ VISA Card # Cardholder n | □ MasterCard | ollege of Pharmacists of BC) | GST 69 137 137 137 137 137 137 137 137 137 137 | 6.56 7.81 |
| □ VISA Card # Cardholder n | □ MasterCard | ollege of Pharmacists of BC) | GST 69 137 137 137 137 137 137 137 137 137 137 | 6.56 7.81 |
| □ VISA Card # Cardholder n | □ MasterCard | ollege of Pharmacists of BC) | GST 69 137 137 137 137 137 137 137 137 137 137 | 6.56 7.81 |
| □ VISA Card # Cardholder n | □ MasterCard | ollege of Pharmacists of BC) | GST 69 137 137 137 137 137 137 137 137 137 137 | 6.56 7.81 |
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| □ VISA Card # Cardholder n Cardholder s | MasterCard name ignature | | GST | 6.56 7.81 |





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.



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

Application Form

| | | CONTACT INFOR | MATION | |
|------------|------------------------------|---------------------------------------|-----------------------------------|--|
| | □ Ms □ Mrs □ | Miss □ Mr □ Dr | | |
| Legal name | Last name (Surname) | First name | Other name(s) | |
| Address | | | Tel (home) | |
| | | | Tel (work) | |
| | | | Email | |
| | City | Province | | |
| | Postal code | Country | | |
| | | | | |
| | | | | |
| | | REQUIRED FEE | S | |
| | | | | |
| □ Reiı | nstatement fee. | | | • |
| | minal Record Check fee | | | |
| | AP Knowledge Assessm | | | |
| | | | | |
| * The full | amount can be applied toward | ls your annual registration fee if yo | u meet the PDAP standards and rei | instate within one year of this application. |
| | | | | |
| | | PAYMENT OP | TION | |
| | | | | |
| ☐ Chequ | ue/Money order (payable | e to College of Pharmacists of BC) | _ | |
| □ VISA | ☐ MasterCard | | | Reinstatement fee * 282.50 PDAP KA fee 525.00 |
| Card # | | | | GST 40.38 |
| Cardholder | name | | | Fotal \$847.88 |
| Cardholder | | | | GST # R106953920 |
| | | | | * Includes criminal record check |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| ☐ I he | ereby authorize the rele | ase of my PDAP status in s | upport of this application f | or reinstatement. |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| _ | Date | | Applicant si | gnature |



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

Notarized Identification

| APPLICAN' | T INFORMATION |
|---|--|
| | |
| Applicant name | |
| Required Documents | |
| Passport photograph, taken within one year, affixed to | o space provided. |
| Copy of name change or marriage certificate if name | |
| from legal name. | on any assument is unterent |
| Required identification - one primary and one | Secondary |
| Identification presented to the Notary Public must be issued by the government agency. Photocopies are acby the issuing government agency to be true copies o | the original document ceptable only if certified |
| PRIMARY Document type Document number | SECONDARY Document type Document number |
| | |
| ☐ Birth certificate | Passport |
| Canadian citizen card | □ Valid Canadian driver's license □ British Columbia identification card |
| ☐ Canadian identity card | |
| | □ Naturalization certificate □ Canadian Forces identification |
| | Canadian Forces identification |
| Date | Applicant signature |
| NOTARY PUBL | IC CERTIFICATION |
| I hereby verify that the person shown in the photograph at Whose name appears as the Applicant. Whose identity has been proven to my satisfacti Whose signature on this document was signed in | on through presentation of the identification indicated. |
| Date | Notary signature |
| | . . |
| ı | Notary name |
| SEAL | Address |
| JEAL | - Tada 655 |
| | |
| | Tel |



Page 4 of 5

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 de | eclar - | e the facts set out herein to be true. |
| | | Date Applicant signature |



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

Criminal Record Check Authorization

| | APPLICANT INFORMATION | | | | |
|-------|--------------------------------|--|---|---|---------------------------------------|
| مم ا | al name | | | | |
| Leg | ai name | Last name (Surname) | First name | Other name(s) | · · · · · · · · · · · · · · · · · · · |
| Mail | ing address | Street | City/town | Province/State | Postal Code |
| | | Country | Contact phone | Area code | |
| _ | | , | | Area code | |
| Gen | der | □ Male □ Female I | 3.C. Driver License | | |
| Birt | h date | YYYY-MM-DD | Birthplace | Province/State | Country |
| Oth | er names used | | ame, birth name, previous married name) | | , |
| | 1. | | | | |
| | 1. | Surname | First name | Middle name | · · · · · · · · · · · · · · · · · · · |
| | 2. | Surname | First name | Middle name | |
| | 3. | | | 1000 | |
| | | Surname | First name | Middle pame | |
| | | FREEDOM OF INFO | RMATION AND PROTECTION OF P | PRIVACY ACT (FOIPPA) | |
| Tho | nformation roa | wested on this form is collected | under the authority of the Criminal Records | Daview Act and in the case of shild s | are facilities, the |
| Com | munity Care Fa | acility Act, and the regulations v | which govern both these acts. The information | n provided will be used to fulfill the re | |
| the (| iriminal Record | Is Review Act for the release of | criminal records information and is in compli | ance with the FOIPPA. | |
| | | CONSENT FOR RE | LEASE OF INFORMATION AND AC | CKNOWLEDGEMENTS | |
| | | Pursua | int to the B.C. Criminal Records R | Review Act | |
| | T haveby seen | and to a shoot for recording | criminal convictions to determine whether I | | |
| • | | offences under the Criminal Rec | | nave a conviction or outstanding cha | irge for |
| • | | | y Registrar any documents in the custody of elevant offence as defined under the Criminal | | nsel relating to |
| • | | sults of this check indicate that ts to verify any such criminal re | a criminal record or outstanding charge for | a relevant offence may exist, I agre | ee to provide |
| • | | Registrar will notify me and my as been referred to the Deputy | organization that I have an outstanding cha Registrar. | arge or conviction for any relevant of | ffence(s) and |
| • | The Deputy R | legistrar will determine whether | or not I present a risk to physical or sexual | abuse to children. | |
| • | The Deputy R I have receive | | disclosed to my organization and it will inclu | ide consideration of any relevant offe | ence for which |
| • | If I am charge | ed with or convicted of a releva | nt offence at any time subsequent to the crin ny organization and provide my organization, | · · · · · · · · · · · · · · · · · · · | |
| | "Deputy Regist | rar" means a person appointed under | the Public Service Act as deputy registrar for the pu | urposes of this Act. | |
| | | | | | |
| | | | | | |
| | | and understood the Conse as indicated by my signati | nt for Release of Information and Acknoure below. | owledgements above. I hereby c | consent to |
| | | | macists of British Columbia to conduct on withdraw this consent for future cri | | joing basis |
| | | | | | |
| | | | | | |
| | | | | | |

Applicant signature



6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACIST REGISTER

CHECKLIST

| V | mile | | hmi |
|-------|------|------|-----|
| T () | | | |
| I UU | must | . 34 | |

| 1. | Ш | Checklist (page 1). |
|----|---|---|
| 2. | | Application form (page 2). |
| 3. | | Notarized identification (use form on page 3). |
| 4. | | Certification of Pharmacy Related Employment (use form on page 4; one form per employer). |
| 5. | | Statutory declaration (use form on page 5). |
| 6. | | Criminal record check authorization (use form on page 6). |

You must submit IF

- □ Evidence of your authorization to work in Canada if you are not a Canadian citizen or a permanent resident. Acceptable documents: Canadian citizenship 7. card, Canadian passport, permanent resident card, social insurance card, or work permit.
- □ 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. 8. 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.



6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACIST REGISTER

Application Form

| | | CONTACT INF | ORMATION | | |
|------------|------------------------|-------------------------------------|--------------------------|----------------------|--------------------|
| | □ Ms □ Mrs | □ Miss □ Mr □ Dr | | | |
| Legal name | Last name (Surname) | First name | Other name(s) | | |
| Address | Last Hame (Surname) | riist name | | (home) | |
| Addicas | | | | | |
| | | | Tel (| (work) | |
| | City | Province | Ema | il | |
| | | | | • | |
| | Postal code | Country | | | |
| | | | | | |
| | | | | | |
| | | REQUIRED F | EES | | |
| | | na ço anao i | | | |
| | | | | | |
| ☐ Reinst | tatement fee. | | | | |
| ☐ Crimir | nal Record Check fee. | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | PAYMENT | OPTION | | |
| ☐ Chec | quo/Monoy order /naveh | le to College of Pharmacists of BC) | i | | |
| | | | | Application fee * | 282.50 |
| □ VISA | A ☐ MasterC | ard | | GST | 14.13 |
| Card # | | | Exp/ | Total | \$296.63 |
| Cardhold | er name | | | | |
| | er signature | | | G | SST # R106953920 |
| Cardiloid | er signature | | | * Includes arise | ninal record check |
| | | | | " Includes Clini | imai recoru check |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| ☐ I here | eby authorize the rele | ase of my PDAP status in s | support of this applicat | ion for reinstatemen | t |
| | , | , | The second second | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | Date | | Applica | ant signature | |
| | | | | - 5 | |



6 YEARS OR MORE 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 of from legal name. | on any document is different |
| Required identification - one primary and one s | secondary. |
| Identification presented to the Notary Public must be t issued by the government agency. Photocopies are acc by the issuing government agency to be true copies of | ceptable only if certified |
| PRIMARY Document type Document number | SECONDARY Document type Document number |
| □ Birth certificate | Passport |
| ☐ Canadian citizen card | Valid Canadian driver's license |
| ☐ Canadian identity card | ☐ British Columbia identification card |
| | ☐ Naturalization certificate |
| | ☐ Canadian Forces identification |
| Date | Applicant signature |
| NOTARY PUBL | IC CERTIFICATION |
| I hereby verify that the person shown in the photograph aff Whose name appears as the Applicant. Whose identity has been proven to my satisfaction Whose signature on this document was signed in | on through presentation of the identification indicated. |
| Date | Notary signature |
| N | lotary name |
| SEAL | Address |
| | Tel |







6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACIST REGISTER

Certification of Pharmacy Related Employment

| | EMPLOYMENT INFORMATION |
|--------------------|---|
| | |
| Applicant name | |
| Applicant name | |
| F | |
| Employer name | |
| Address | |
| | |
| | |
| T-1 | |
| Tel | Fax |
| | |
| Position | Total hours worked |
| Start date | End date |
| | |
| | EMPLOYER CERTIFICATION |
| I certify that the | above employment information is correct. |
| Name | |
| Position | |
| Position | Pharmacy Manager / Pharmacy Owner / Human Resources Manager |
| | |
| | |



Page 5 of 6

6 YEARS OR MORE 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 de | clare | e the facts set out herein to be true. |
| | _ | Date Applicant signature |



6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACIST REGISTER

Criminal Record Check Authorization

| | | APPLICANT INFORMATION | | | |
|--|--|---|------------------------------|-------------|--|
| | | | | | |
| Legal name | Last name (Surname) | First name | Other name(s) | | |
| Mailing addre | Street | City/town | Province/State | Postal Code | |
| | Country | Contact phone | Area code | | |
| Gender | □ Male □ Female | B.C. Driver License | | | |
| Birth date | YYYY-MM-DD | Birthplace | Dunying a Chaha | Country | |
| Other names | | name, birth name, previous married name) | Province/State | Country | |
| | 1. | | | | |
| | Surname 2. | First name | Middle name | | |
| | Surname 3. | First name | Middle name | | |
| | Surname | First name | Middle pame | | |
| | FREEDOM OF INF | ORMATION AND PROTECTION OF P | RIVACY 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 will determine whether or not I present a risk to physical or sexual abuse to children. The Deputy Registrar of 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 | | | | | |
| | | | | | |
| | read and understood the Con erms as indicated by my sign | sent for Release of Information and Ackno ature below. | owledgements above. I hereby | consent to | |
| □ I hereb basis ev | □ 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. | | | | |

Applicant signature

Date



Late Registration Renewal

□ UBC Student Pharmacist

| | | CONTACT INFORMA | TION |
|-------------------------------|--------------------------------|--------------------------------|--|
| | □ Ms □ Mrs □ | Miss □ Mr □ Dr | |
| Legal name | Last name (Surname) | First name | Other name(s) |
| Address | , , | This name | Tel (home) |
| | | | Tel (work) |
| | | | Email |
| | City | Province | Elitair |
| | Postal code | Country | |
| | | | |
| | | 4 | |
| | | PAYMENT OPTIO | ON . |
| □ VISA Card # Cardholder na | Money order (payable to Colleg | AX | Late renewal fee 52.50 GST 2.63 Total \$55.13 GST # R106953920 |
| | | | |
| I have com | apleted and attached my an | nual registration renewal form | together with the necessary fees. |
| | Date | | Applicant signature |



90 DAYS OR MORE ON INACTIVE STUDENT REGISTER

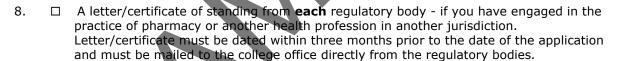
CHECKLIST

You must submit

| 6. | Criminal record check authorization (use form on page 5). |
|----|---|
| 5. | Statutory declaration (use form on page 4). |
| 4. | Notarized identification (use form on page 3). |
| 3. | Copy of letter from UBC confirming registration with Faculty of Pharmacy. |
| 2. | Application form (page 2). |
| 1. | Checklist (page 1). |

You must submit IF

| 7. | 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. |



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.



90 DAYS OR MORE ON INACTIVE STUDENT REGISTER

Application Form

| | | | CONTA | ACT INFOR | MATION | | |
|------------|----------------------------|---------------------|-------------|-----------|---------------|-------------------|--------------------|
| | □ Ms □ Mrs | □ Miss | □ Mr | □ Dr | | | |
| Legal name | Last name (Surname) | | First nar | me | Other name(s, |) | |
| Address | | | | | | | |
| | | | | | Tel | (work) | |
| | | | | | Em | | |
| | City | | Province | 2 | | | |
| | Postal code | | Country | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | REQL | JIRED FEE | s | | |
| | | | | | | | |
| | | | | | | * | |
| ☐ Reins | tatement/renewal f | ee. | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | \ | | | | |
| | | 4 | | 17 | • | | |
| | | | PA | YMENT OF | TION | | |
| ☐ Chec | que/Money order <i>(pa</i> | unbla to Callaga of | Obaymaciat | of BC) | | | |
| □ VISA | | | Priarmacist | S U(BC) | | Application fee * | 52.50 |
| | | erCard | | | _ | GST | 2.63 |
| | | | | | Exp/ | Total | <u>\$55.13</u> |
| | ler name | | | | | | GST # R106953920 |
| Cardhold | er signature | | | | | | |
| | | | | | | * Includes crin | ninal record check |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Data | | | | A 1 | icant cignature | |
| | Date | | | | Аррі | icant signature | |



90 DAYS OR MORE ON INACTIVE STUDENT REGISTER

Notarized Identification

| APPLICANT I | NFORMATION |
|---|---|
| | |
| Applicant name | |
| Required Documents | |
| Passport photograph, taken within one year, affixed to sp | pace provided. |
| Copy of name change or marriage certificate if name on | any document is different |
| from legal name. | |
| Required identification - one primary and one sec | condary. |
| Identification presented to the Notary Public must be the | |
| issued by the government agency. Photocopies are accep by the issuing government agency to be true copies of the | |
| by the issuing government agency to be true copies of the | Congiliali |
| | |
| PRIMARY Document type Document number | SECONDARY Document type Document number |
| | |
| ☐ Birth certificate ☐ Canadian citizen card | Passport Valid Canadian driver's license |
| | British Columbia identification card |
| | Naturalization certificate |
| | Canadian Forces identification |
| Date | Applicant signature |
| NOTARY PUBLIC | CERTIFICATION |
| I hereby verify that the person shown in the photograph affixe Whose name appears as the Applicant. Whose identity has been proven to my satisfaction Whose signature on this document was signed in m | through presentation of the identification indicated. |
| | Notary signature |
| Note | ary name |
| SEAL | Address |
| | |
| | |
| | Tel |



90 DAYS OR MORE ON INACTIVE STUDENT 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. | | | |
| | Г | a charge relating to an offense under any Act regulating the practice of pharmacy or relating to the sale of drugs, or relating to any criminal offense; a finding of guilt in relation to an offense under any Act regulating the practice of pharmacy or 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 de | clare | e the facts set out herein to be true. | | | |
| | _ | Date Applicant signature | | | |



90 DAYS OR MORE ON INACTIVE STUDENT REGISTER

Criminal Record Check Authorization

| | | | APPLICANT INFORMATION | ON | |
|-------|--------------------------------|---|--|--|---------------------------------------|
| Lega | al name | | | | · |
| Mail | ing address | Last name (Surname) | First name | Other name(s) | |
| | | Street | City/town | Province/State | Postal Code |
| | | Country | Contact pho | Area code | |
| Gen | der | □ Male □ Female E | 3.C. Driver License | | |
| Birth | n date | | Birthplace | | |
| Othe | er names used | YYYY-MM-DD d or have used (e.g. maiden na | City/town me, birth name, previous married name) | Prevince/State | Country |
| | | () 3 | ,, | | |
| | 1. | Surname | First name | Middle name | · · · · · · · · · · · · · · · · · · · |
| | 2. | Surname | First name | Middle name | |
| | 3. | Surname | First name | Middle ,áme | ····· |
| | | Samame | r i se name | nade vienne | |
| | | FREEDOM OF INFO | RMATION AND PROTECTION C | OF PRIVACY ACT (FOIPPA) | |
| | | | | ords Review Act and in the case of child ca | |
| | | | thich govern both these acts. The inform criminal records information and is in co | nation provided will be used to fulfill the recompliance with the FOIPPA. | quirements of |
| | | | | | |
| | | CONSENT FOR RE | LEASE OF INFORMATION AND | D ACKNOWLEDGEMENTS | |
| | | Pursua | nt to the B.C. Criminal Record | ds Review Act | |
| • | | | | er I have a conviction or outstanding cha | rge for |
| • | I hereby auth | | | dy of the police, the court and crown coun | sel relating to |
| • | Where the re | | a criminal record or outstanding charg | e for a relevant offence may exist, I agre | e to provide |
| • | The Deputy R | | organization that I have an outstanding | g charge or conviction for any relevant of | fence(s) and |
| • | | | or not I present a risk to physical or sex | xual abuse to children. | |
| • | The Deputy R I have receive | | disclosed to my organization and it will | include consideration of any relevant offe | nce for which |
| • | agree to repo | | | e criminal record check authorized herein, tion, in a timely manner, with a new-signe | |
| | "Deputy Registi | rar" means a person appointed under | the Public Service Act as deputy registrar for | the purposes of this Act. | |
| | | | | | |
| | | and understood the Conser as indicated by my signatu | | acknowledgements above. I hereby c | onsent to |
| | | | nacists of British Columbia to condu at I may withdraw this consent for | uct criminal record checks on an ongo future criminal record checks. | oing |
| | | | | | |
| | | | | | |
| | | | | | |

Applicant signature

Date



LESS THAN 6 YEARS IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN 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.



LESS THAN 6 YEARS IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN REGISTER

Application Form

| | | CONTACT INFORMATI | ON |
|-----------------------|---|------------------------------|--|
| | ☐ Ms ☐ Mrs ☐ Miss | s □ Mr □ Dr | |
| Legal name Address | Last name (Surname) | First name | Other name(s) Tel (home) Tel (work) |
| | | | Email |
| | City | Province | |
| | Postal code | Country | |
| | instatement fee. minal Record Check fee. | REQUIRED FEES | |
| ☐ VIS | eque/Money order (payable to Sol SA | | Reinstatement fee * 177.50 GST |
| | I hereby authorize the rele | ease of my PDAP status in si | upport of this application for reinstatement |
| | Date | | Applicant signature |



LESS THAN 6 YEARS IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN REGISTER

Notarized Identification

| | | APPLICANT INFORM | ATION | |
|-----------------------------|-----------------------|---|----------------------------------|-----------------|
| | | | | |
| Applicant name | | | | |
| Required Docur | nents | | | |
| Passport photog | raph, taken within or | ne year, affixed to space prov | rided. | |
| | | ertificate if name on any docu | ument is different | |
| from legal name | 2. | | | Dhata |
| Required identif | ication - one prin | nary and one secondary | /. | Photo |
| | • | y Public must be the origina l | | |
| | | notocopies are acceptable only be true copies of the origina | | |
| , 33 | <i>3</i> , | , , | | |
| | | | \ | |
| Documen | PRIMARY t type Doo | cument number | SECONDARY Document type | Document number |
| □ Birth certifi | | □ Passp | | |
| ☐ Canadian c | | | Canadian driver's license | |
| | dentity card | | h Columbia identification card | |
| | | □ Natu | ralization certificate | |
| | | ☐ Cana | dian Forces identification | |
| | | | | <u> </u> |
| | | | | |
| | | | | |
| | Date | | Applicant signat | ture |
| | | | | |
| | | NOTARY PUBLIC CERTIF | ICATION | |
| | | V | | |
| I hereby verify that t | the person shown in t | he photograph affixed on this | s page is the same person: | |
| Whose nar | me appears as the Ap | oplicant. | | |
| | | | presentation of the identificati | on indicated. |
| ■ Whose sig | nature on this docum | ent was signed in my presen | ce. | |
| | | | | |
| | | | | |
| | Date | | Notary signatu | ure |
| | 24.0 | | , o.gaca | |
| | | Notary name | | |
| CF | AL | Address | | |
| 36 | AL | Addiess | | |
| | | | | |
| | | Tel | | |



Page 4 of 5

LESS THAN 6 YEARS IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN 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 regulating the practice of pharmacy or relating to the sale of drugs, or relating to any criminal offense; a finding of guilt in relation to an offense under any Act regulating the practice of pharmacy or 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 ded | clare | e the facts set out herein to be true. |
| | _ | Date Applicant signature |



LESS THAN 6 YEARS IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN 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 |
| | Country | Contact phone | eArea code | |
| Gender | □ Male □ Female B. | C. Driver License | | |
| Birth date | Bir | thplace | | |
| | YYYY-MM-DD | City/town | Prevince/State | Country |
| Other names use | ed or nave used (e.g. maiden nam | ne, birth name, previous married name) | | |
| 1. | Surname | First name | Middle name | |
| 2. | Surname | First name | Middle name | |
| 3. | Surname | First name | Middle vame | · · · · · · · · · · · · · · · · · · · |
| | | | | |
| | FREEDOM OF INFOR | MATION AND PROTECTION OF | PRIVACY ACT (FOIPPA) | |
| | | nder the authority of the Criminal Recorich govern both these acts. The informat | | |
| | | iminal records information and is in com | | requirements of |
| | CONSENT FOR REL | EASE OF INFORMATION AND | ACKNOWLEDGEMENTS | |
| | Pursuan | t to the B.C. Criminal Records | Review Act | |
| | nsent to a check for records of cri t offences under the Criminal Reco | minal convictions to determine whether | I have a conviction or outstanding c | narge for |
| I hereby aut | thorize the release to the Deputy | Registrar any documents in the custody country offence as defined under the Crimi | | unsel relating to |
| Where the r | | a criminal record or outstanding charge | | ree to provide |
| The Deputy | | rganization that I have an outstanding | charge or conviction for any relevant | offence(s) and |
| | | r not I present a risk to physical or sexu | al abuse to children. | |
| | Registrar's determination will be dived a pardon. | isclosed to my organization and it will in | clude consideration of any relevant of | fence for which |
| agree to rep | | offence at any time subsequent to the organization and provide my organization | | |
| "Deputy Regis | strar" means a person appointed under to | he Public Service Act as deputy registrar for the | e purposes of this Act. | |
| | | | | |
| | d and understood the Consent ns as indicated by my signatur | for Release of Information and Acle below. | knowledgements above. I hereby | consent to |
| | | acists of British Columbia to conduc y withdraw this consent for future o | | ngoing basis |
| | | | | |
| | | | | |
| | | | | |

Applicant signature

Date





6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN REGISTER

CHECKLIST

You must submit

| 1. | Checklist (page 1). |
|----|---|
| 2. | Application form (page 2). |
| 3. | Notarized identification (use form on page 3). |
| 4. | Certification of Pharmacy Related Employment (use form on page 4; one form per employer). |
| 5. | Statutory declaration (use form on page 5). |
| 6. | Criminal record check authorization (use form on page 6). |

You must submit IF

- 7. 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.
- 8.

 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.



6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN REGISTER

Application Form

| | | CONTACT INFOR | MATION | |
|-----------------|--|-------------------------------|-------------------------------------|------------------------------|
| | □ Ms □ Mrs □ | Miss □ Mr □ Dr | | |
| Legal name | Last name (Sumame) | First name | Other many (a) | |
| Address | Last name (Surname) | First name | Other name(s) | |
| 7 1441 555 | | | Tel (work) | |
| | | | | |
| | City | Province | Email | |
| | Postal code | Country | | |
| | | | | > |
| | tatement fee. nal Record Check fee. | REQUIRED FEES | | |
| | | PAYMENT OP | TION | |
| ☐ Chec | que/Money order (payable to | College of Pharmacists of BC) | | |
| □ VISA | | | Application | fee * 177.50 |
| | | | GST Exp/ Total | 8.86 |
| | | | Total | <u>\$186.36</u> |
| Cardholder name | | | GST # R106953920 | |
| Cardhold | er signature | | * Inc | cludes criminal record check |
| | | | | |
| | | | | |
| □ I here | eby authorize the release | of my PDAP status in sup | port of this application for reinst | atement |
| | Date | | Applicant signature | |



6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN REGISTER

Notarized Identification

| | APPLICANT INFORMA | ATION | |
|--|------------------------------|------------------------------|-----------------|
| | | | |
| Applicant name | | | |
| Required Documents | | | |
| Passport photograph, taken within one | year, affixed to space provi | ded. | |
| Copy of name change or marriage certification | ficate if name on any docu | ment is different | |
| from legal name. | | | Photo |
| Required identification - one prima | ry and one secondary | | Piloto |
| Identification presented to the Notary Prissued by the government agency. Phot | | | |
| by the issuing government agency to be | | | |
| | | | |
| PRIMARY | | SECONDARY | |
| | nent number | Document type | Document number |
| ☐ Birth certificate | □ Passpo | ort | |
| ☐ Canadian citizen card | □ Valid (| Canadian driver's license | |
| ☐ Canadian identity card | ☐ British | Columbia identification card | |
| | ☐ Natura | alization certificate | |
| | ☐ Canad | lian Forces identification | |
| Date | | Applicant signal | ture |
| N | OTARY PUBLIC CERTIF | ICATION | |
| | | | |
| hereby verify that the person shown in the | photograph affixed on this | page is the same person: | |
| Whose name appears as the Appli | cant. | | |
| Whose identity has been proven to | | | ion indicated. |
| Whose signature on this document | t was signed in my presenc | œ. | |
| | | | |
| | | | |
| Date | | Notary signatu | ire |
| | | . • | |
| | Notary name | | |
| SEAL | Address | | |
| | | | |
| | | | |
| | Tel | | |



6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN REGISTER

Certification of Pharmacy Related Employment

| | EMPLOYMENT INFORMATION |
|-------------------|---|
| | |
| Applicant name | |
| I. I | |
| Employer name | |
| Address | |
| Addi ess | |
| | |
| Tel | Fex |
| TCI | |
| Position | Total hours worked |
| Start date | End date |
| | |
| | EMPLOYER CERTIFICATION |
| I certify that th | ne above employment information is correct. |
| Name | |
| Position | |
| | Pharmacy Manager / Pharmacy Owner / Human Resources Manager |
| | |
| | |
| - | Date Employer signature |

Page 5 of 6

6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN 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

| [, | | | 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 regulating the practice of pharmacy or relating to the sale of drugs, or relating to any criminal offense; a finding of guilt in relation to an offense under any Act regulating the practice of pharmacy or 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 speet 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 | decl | lare | e the facts set out herein to be true. |
| | | | |
| | | _ | Date Applicant signature |



6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN REGISTER

Criminal Record Check Authorization

| | | | APPLICANT INFORMATIO | N | |
|------|--------------------------------|---|---|--|--------------------|
| | | | | | |
| Leg | al name | Last name (Surname) | First name | Other name(s) | |
| Mail | ling address | Street | City/town | Province/State | Postal Code |
| | | | Contact phor | | |
| | | Country | | Area code | |
| Gen | der | □ Male □ Female | B.C. Driver License | | |
| Birt | h date | VOOC MM DD | Birthplace | Devision of Charles | Country |
| Oth | er names use | YYYY-MM-DD d or have used (e.a. maide | City/town en name, birth name, previous married name) | Province/State | Country |
| | | | , , , , , , , , , , , , , , , , , , , | | |
| | 1. | Surname | First name | Middle name | |
| | 2. | Surname | First name | Middle dame | |
| | 3. | Samanic | Trist hanc | riidaic same | |
| | | Surname | First name | Middle name | |
| | | FREEDOM OF IN | FORMATION AND PROTECTION O | F PRIVACY ACT (FOIPPA) | |
| | | | | · · · · · · · · · · · · · · · · · · · | |
| | | | cted under the authority of the Criminal Reco ns which govern both these acts. The informa | | |
| | | | e of criminal records information and is in con | | |
| | | CONSENT FOR | RELEASE OF INFORMATION AND | ACKNOWLEDGEMENTS | |
| | | | suant to the B.C. Criminal Record | | |
| | | Puis | suant to the B.C. Criminal Records | S Keview Act | |
| • | | sent to a check for records offences under the Criminal | of criminal convictions to determine whethe Records Review Act. | r I have a conviction or outstanding | charge for |
| • | | | puty Registrar any documents in the custody ny relevant offence as defined under the Crim | | ounsel relating to |
| • | | sults of this check indicate ats to verify any such crimin | that a criminal record or outstanding charge al record. | for a relevant offence may exist, I a | gree to provide |
| • | | Registrar will notify me and as been referred to the Depo | my organization that I have an outstanding uty Registrar. | charge or conviction for any relevan | t offence(s) and |
| • | The Deputy R | Registrar will determine whe | ther or not I present a risk to physical or sex | ual abuse to children. | |
| • | The Deputy R I have receive | _ | Il be disclosed to my organization and it will i | nclude consideration of any relevant o | offence for which |
| • | agree to repo | | levant offence at any time subsequent to the to my organization and provide my organization | | · |
| | "Deputy Regist | trar" means a person appointed ι | under the Public Service Act as deputy registrar for the | ne purposes of this Act. | |
| | | | | | |
| | | | | | |
| | | and understood the Col as as indicated by my sign | nsent for Release of Information and Ac nature below. | knowledgements above. I hereb | y consent to |
| | | | armacists of British Columbia to conduct that I may withdraw this consent for fo | | ngoing |
| | | | | | |

Applicant signature

Date







APPLICATION FORCERTIFICATION – INJECTION DRUG ADMINISTRATION

| | | APPLIC | CANT INFORMAT | ON |
|--|--|-------------------------------|----------------------------|--|
| | □ Ms □ Mrs | □ Miss □ Mr | □ Dr | Reg # |
| Legal name | | First name | Ot | ther name(s) |
| Address | | | | Tel (home) |
| | | | | Tel (work) |
| | City | Province | | Email |
| | Postal code | Country | | |
| | | PAY | MENT OPTION | |
| □ VISA Card # _ Cardholder: *Includes cu | namesignature wrent year's certification fee (value) at I am in compliance with | lid to end of current year to | sions Act, the Phar | Application Fee* 105.00 GST 5.25 Total \$110.25 GST # R106953920 macy Operations and Drug Scheduling Act, the writish Columbia made pursuant to these Acts. |
| I have atta | ached: | | | |
| | Signed Declaration Form (| page 2). | | |
| | Copy of certificates of comple of drugs by injection. | etion of training from a C | follege approved accred | lited program in the administration |
| | Copy of certificates of comple | etion of training in the ad | lministration of first aid | I and CPR. |
| | Date | | - | Applicant signature |



APPLICATION FOR

CERTIFICATION - INJECTION DRUG ADMINISTRATION

Declaration Form

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF MY APPLICATION TO THE COLLEGE OF PHARMACISTS OF BC FOR CERTIFICATION - INJECTION DRUG ADMINISTRATION

| Ι, _ | | | declare that (check the appropriate boxes): |
|------|---|----|---|
| I | _ | | 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. |
| [| | 2. | I am registered as a full pharmacist with the College of Pharmacists of BC. |
| [| | 3. | I will abide by the standards, limits and conditions that apply to the administration of drugs by injection and restrict my practice to those areas in which I am competent. |
| [| | 4. | I have successfully completed training from a College approved accredited program in the administration of drugs by injection. |
| [| | 5. | I have successfully completed training in the administration of first aid and CPR and will maintain valid first aid certification and CPR certification for the duration of my authorization, and that if I am unable to provide proof of certification, my authorization to administer injections will be cancelled. |
| [| | 6. | I will engage in the restricted activity of administering drugs by injection only after having received approval from the College of Pharmacists of BC. |
| 1 | | 7. | 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. |
| | | | |
| | | | e this declaration, conscientiously as it to be true and knowing that it is of the same force and effect as if under oath. |
| | | | Date Applicant signature |





0

APPLICATION FOR NEW PHARMACY

Community

| | ☐ Sole proprietor / Partnership |
|---------------------|--|
| Date | - |
| | |
| Tel | |
| Fax | |
| Postal code Email | |
| | * Obaymagist |
| Director | * Pharmacist |
| | |
| | |
| | |
| IACY INFORMATION | |
| | • |
| Tel | |
| Fax | |
| Postal sode Manager | |
| Contact + | |
| Tel + | |
| Fax ⁺ | |
| + Only | y if manager not available before opening |
| T OPTION | |
| | |
| | Application Fee 525.00 Initial Licence Fee 1,181.25 |
| Exp/ | GST <u>85.31</u> |
| | Total \$1,791.56 |
| | GST # R106953920 |
| | Fax Email Director MACY INFORMATION Tell Fax Manager Contact + Tel + Fax + only |

Date

Position



APPLICATION FOR NEW PHARMACY

Community

Application must be received by the College Office at least 10 weeks prior to the proposed opening date. The following must be submitted together with this application: Diagram detailing the layout (see diagram requirement checklist below) Copy of the Certificate of Incorporation Copy of the certified Incorporation Application Copy of the certified Notice of Articles Copy of valid business licence The following must be submitted at least 2 weeks prior to opening: Acknowledgement of Completion of Confidentiality form

DIAGRAM REQUIREMENT CHECKLIST The following information must be included on the diagram: scale: 1/4 inch = 1 foot Dispensary area size - minin um $15 \text{ m}^2 (160 \text{ sq ft})$ inters - minimum 3 m² (30 sq ft) Dispensary area col ² (40 sq ft) of shelf space Storeroom space ninimum 4 r of the front counter and shelf height Location f the double stainless steel sink Location of the refrigerator Location and type of consultation area (semi-private or private) binet and/or safe orage c type of security system of Professional Service Area or Schedule 2 items, if applicable П Location of Professional Product Area or Schedule 3 items - visible and up to 7.6 m (25 ft) from dispensary, if applicable Location of "Medication Information" sign, if applicable The following information must be provided: Description of how the professional service area is made visually distinctive or indicate location of Pharmacy signs: Description of the method used to make the dispensary inaccessible to the public:

Page 1 of 2



Hospital

APPLICATION FOR NEW PHARMACY

| | | APPLICANT INFO | DRMATION | | |
|----------------------|------------------------------|---------------------------|---|----------------------------|--------------------|
| ☐ Corporation | | | | | |
| | ation # | Incorporation Dat | te | _ | |
| | | | | | |
| Hospital name | | | | | |
| Address | | | Tel | | |
| | | | Fax | | |
| | | Post | Email | | |
| | | POST | ai code | | |
| | Director * | <u>Pharmacist</u> | Director | * | <u>Pharmacist</u> |
| | | 🗆 | | | |
| | | | | | |
| * Majority must be I | BC licensed pharmacists | | | | _ |
| | | | | | |
| | Р | ROPOSED PHARMAC | CY INFORMATION | | |
| | | | | | |
| perating name | | | | | |
| Address | | | Tél | | |
| | | | Fax | | |
| | | Postal | Manager | | |
| | | | Contact + | | |
| Opening date | | | Tel + | | |
| Software Vendor | | | Fax + | | |
| Software vendor | | 13 | | y if manager not available | |
| | | | <i>G</i> , | , ii manager net avanabre | s zerere opermig |
| | | PAYMENT C | PTION | | |
| ☐ Cheque/Mone | ey order (payable to College | of Pharmacists of BC) | Г | | |
| | MasterCard | | | Application Fee | 525.00 |
| Card # | | | Exp/ | Initial License Fee | 1,181.25 |
| Cardholder na | me | | L^p/ | GST | 85.31 |
| Cardholder sig | | | | Total | <u>\$1,+- %) *</u> |
| Cardifolder sig | illature | | | GS ⁻ | T # R106953920 |
| | | | | | |
| | | | | | |
| | | | | | |
| I attest that: | | | | | |
| ☐ The Pharmac | y is in compliance with t | the Health Professions | Act, the Pharmacy Oper sts of British Columbia m | ations and Drug Sc | theduling Act, |
| | | | | | |
| ☐ I have read a | na understood the Pharn | nacy Licensure in British | n Columbia – Information | Guide and Resource | s раскаде. |
| | | | | | |
| | | | | | |
| | Name (please print) | | Signa | ture | |
| | | | | | |
| | Position | | Da | te | |

APPLICATION FOR NEW PHARMACY





APPLICATION REQUIREMENT CHECKLIST

Application must be received by the College Office at least 8 weeks prior to the proposed opening date. The following must be submitted together with this application: Diagram detailing the layout (see diagram requirement checklist below) Copy of the Certificate of Incorporation Copy of the certified Incorporation Application Copy of the certified Notice of Articles The following must be submitted at least 2 business days prior to opening: Acknowledgement of Completion of Confidentiality Fa

DIAGRAM REQUIREMENT CECKLIST

| e follo | owing information must be included on the diagram: scale: ¼ inch = 1 foot |
|----------|--|
| | Dispensary area size - minimum 15 m² (160 sq. ft.) |
| | Dispensary area counters - minimum 3 m² (30 sq. ft.) |
| | Storeroom space - minimum 4 m² (40 sq. ft.) of shelf space |
| | Description of the front counter and shelf height |
| | Location of the double stainless steel sink |
| | Location of the refrigerator |
| | Location and type of consultation area (semi-private or private) |
| | Drug storage cabinet and/or safe |
| | Type of security system |
| | Location of Professional Service Area or Schedule 2 items, if applicable |
| | Location of Professional Product Area or Schedule 3 items - visible and up to 7.6 m (25 ft) from dispensary, if applicable |
| | Location of "Medication Information" sign, if applicable |
| ne follo | owing information must be provided: |
| | Description of how the professional service area is made visually distinctive or indicate location of Pharmacy signs: |
| | Description of the method used to make the dispensary inaccessible to the public: |



APPLICATION FOR NEW PHARMACY

Education Site

| | APPLICANT 1 | NFORMATION | |
|--|--|-------------------|---|
| ☐ Corporation | | | ☐ Sole proprietor / Partnership |
| Cert. of Incorporation # | Incorporation | on Date | - |
| Company name | | | |
| Address | | Tel | |
| | | Fax | |
| | | Postal code Email | |
| | | | |
| | PROPOSED PHAR | MACY INFORMATION | |
| | TROP COLD THAIR | | |
| stitution name Address | | Tel | |
| | | Fax | |
| | | Manager Manager | |
| | | Contact + | |
| Opening date | | Tel + | |
| | | Fax + | y if manager not available before opening |
| ☐ Cheque/Money orde☐ VISA ☐ Mas Card # Cardholder name | er (payable to College of Pharmacists of BC) | NT OPTION Exp/ | Application Fee 525.00 Initial License Fee 315.00 GST 42.00 |
| Cardholder signature | | | Total \$882.00 |
| | | | GST # R106953920 |
| | | | |
| | | | |
| I attest that: | | | |
| | compliance with the Health Profess I the Bylaws of the College of Phari | | |
| | derstood the Pharmacy Licensure in E | | · |
| | | | |
| N | lame (please print) | Signa | ture |
| | | | |
| | Position | Da | te |



Page 1 of 2



APPLICATION FOR TELEPHARMACY SERVICES

| | APPLICAN | IT INFORMATION | | | |
|---|---|-----------------------|-------------|--------------------------------|------------------|
| | | | | | |
| Company name | | | | | |
| Central pharmacy | | | | | |
| Pharmacy manager | | | | | |
| Address | | | Tel | | |
| | | | Fax | | |
| | | Postal code | Email | | |
| | | | | • | |
| | PROPOS | SED REMOTE SITE | | | |
| | | | | | |
| Operating name | | | V | | |
| Address | | | | | |
| | | | | | |
| | | | | Postal code | |
| Tel | | | | i ostai code | |
| Fax | | | | | |
| Email | | | | | |
| Hours of operation for Telepharmacy | | | | | |
| | | | | | |
| | | • | | | |
| | PAY | MENT OPTION | | | |
| ☐ Cheque/Money order (paye | able to College of Pharmacists of E | 3C) | Г | | |
| □ VISA □ MasterCar | d | | | Application Fee Licence Fee | 525.00 210.00 |
| Card # | | Exp/_ | | GST . | 36.75 |
| Cardholder name | | | | Total | \$771.75 |
| Cardholder signature | | | | GST | # R106953920 |
| | | | | | |
| | | | | | |
| | | | | | |
| I attest that: | | | | | |
| ☐ The Pharmacy is in complethe Regulation and the F | liance with the Health Pro Bylaws of the College of Pl | fessions Act, the Pha | rmacy Opera | ations and Drug Sch | neduling Act, |
| _ | od the Pharmacy Licensure | | | · | |
| Thave read and anderstoo | to the mannacy Electionic | Distant columbia | | calac and nesources | packagei |
| | | | | | |
| Name (p | please print) | | Signat | cure | |
| | | | | | |
| Po | sition | | Dat | e | |



APPLICATION FOR TELEPHARMACY SERVICES

| | ion must be received by the College Office <u>at least 60 days</u> prior to t operation of telepharmacy. |
|----------------------|--|
| Applicat services | ion must be approved PRIOR to commencement of telepharmacy |
| The foll | owing must be submitted together with this application: |
| | Diagram detailing the layout of the telepharmacy services at the remote s |
| | Copy of final Policy and Procedure Manual which outlines specific telepharmacy operations (see template on College website at www.bcpharmacists.org) |
| PharmaN | et Connection for both sites? |



Page 1 of 2

APPLICATION FOR HOSPITAL SATELLITE



| | APPLI | CANT INFORMATION | | |
|--------------------------|--|--|---------------------|-----------------|
| _ | | | | |
| Company name | | | | |
| Central pharmacy | | | | |
| Pharmacy manager | | | | |
| Address | | Te | el | |
| | | Fa | x | |
| | | Ema | il | |
| | | Postal code | | |
| | | | | |
| | PRO | POSED REMOTE SITE | | |
| | | | | |
| Remote Site _ | | | | |
| Address _ | Name of pharmacy | | V | |
| _ | | | • | |
| = | | | Postal code | |
| Tel _ | | —————————————————————————————————————— | | |
| Fax _ | | | | |
| Email _ | | | | |
| Hours of operation _ | | | | |
| for Satellite | | | | |
| | | | | |
| | P | AYMENT OPTION | | |
| | | | | |
| | order (payable to College of Pharmacists | of BC) | Application Fee | 525.00 |
| | MasterCard | From / | Licence Fee GST | 210.00 36.75 |
| Card # Cardholder nam | | Exp/ | Total | \$771.75 |
| Cardholder sign | | | : GST | # R106953920 |
| Caranolaer sign | uture | | | |
| | | | | |
| | | | | |
| | | | | |
| I attest that: | | | | |
| | | Professions Act, the Pharmacy Open of Pharmacists of British Columbia | | |
| _ | | ure in British Columbia – Information | | |
| □ Thave read all | u understood the Pharmacy Licens | are in prinipii Columbia – IllioiMdhol | oulue and Resources | packaye. |
| | | | | |
| | Name (please print) | Sigr | nature | |
| | | | | |
| | Position | | Pate | |



APPLICATION FOR HOSPITAL SATELLITE

Application must be received by the College Office at least 60 days prior to the planned operation of 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 satellite services at the remote site Copy of final Policy and Procedure Manual which outlines specific hospital satellite operations (see template on College website at www.bcpharmacists.org) PharmaNet Connection for both sites?

FORM 4



COMMUNITY PHARMACY LICENCE RENEWAL NOTICE

| | Date |
|---|---|
| D\ Ufa UWhA UbU[Yf | |
| Pharmacy Address City, Prov, Postal Code | |
| Dear Pharmacy Manager: Pharmacy Licensure Expiry: | |
| Pharmacy Licensure Expiry: | |
| Enclosed please find your Pharmacy Licence Renewal Notice. Note that all fields of informandatory. Terms of a pharmacy licence renewal can be found in the Pharmacy Opera Scheduling Act (PODSA), section 3. | |
| Pages 1 and 2 must be completed, signed and returned with payment and a copy of th business licence. If the College does not receive your completed renewal package on clicence expiry date, your pharmacy must remain closed until the College confirms reins pharmacy licence. Terms of reinstatement of your pharmacy licence can be found in P Please note that it is a contravention of the Pharmacy Operations and Drug Scheduling unlicensed pharmacy. | or before your statement of your ODSA, section 4. |
| If you are enclosing individual pharmacist registration fees with your remittance, include Pharmacist Registration Renewal Notice so we can track whose fees are covered by the | le each individual payments. |
| If you have any questions or comments, please feel free to contact: Doris Wong Administrative Assistant - Renewals & Records (604) 676-4224 or doris.wong@bcpharmacists.org | |
| Yours truly, | |
| Registrar | |

| ID# | • |
|-------------------------|---|
| Pharmacare # | • |
| Current licence expires | |

| | PHARMACY |
|---|---|
| Pharmacy Manager Pharmacy Address City, Prov Postal Code | Tel: * Fax: * Email: * * required information - please provide update |
| | |

Name of Owner (Corporation or Sole Proprietor)
Corporate Director(s)

Has there been a change of directors? If yes, a copy of Notice of Articles A Notice of Directors must be provided.

| | FEE GST | TOTAL | | |
|--|----------------------------------|------------------------|-------|-------------|
| Pharmacy licence fee | \$1,181.25 + \$59.96 = \$ | 1,8(\$.' % | | ~1,&(\$.' % |
| Pharmacist registration (option | onal) | | | |
| Full Pharmacist registration fee | \$630.00 +\$31.50 = | \$* * %) 0 | X | = \$ |
| Full Pharmacist registration fee with building assessment | \$682.50 + \$34.13 = | ઁ+%ੈ ™' | X = | \$ |
| | | | | |
| Non-Practising Pharmacist registration | pr fee \$504.00 + \$25.20 = | *) &- "&\$ | X · = | \$ |
| Non-Practising Pharmacist registration | ree \$504.00 + \$25.20 = | ˇ) &- ''&\$ | X · = | <u> </u> |
| | | ˇ) &- ''&\$ | | <u> </u> |
| Payment option | to College of Pharmacists of BC) | `) &- " &\$ | | <u> </u> |
| Payment option ☐ Cheque/Money order <i>(payable</i> ☐ VISA ☐ MasterCa | to College of Pharmacists of BC) | | | <u> </u> |
| Payment option ☐ Cheque/Money order <i>(payable</i> ☐ VISA ☐ MasterCa | to College of Pharmacists of BC) | | | <u> </u> |

Please return this notice with payment



COMMUNITY PHARMACY LICENCE RENEWAL NOTICE

| ID # | |
|-------------------------|---|
| Pharmacare # | • |
| Current licence expires | |

| STAFF P | HARMACISTS |
|--|--|
| Confirm if the following are still employed at this pha | rmacy by checking one of the checkboxes |
| Current employee? Name | Reg # Status Renewed To |
| Yes No | |
| Yes No | |
| Add Pharmacists not listed above in the following tal | Reg # Full time Part time Casual |
| | |
| | |
| | |
| | |
| (PODSA), the Regulation and the Bylaws of the College of | s Act (HPA), the Pharmacy Operations and Drug Scheduling Act Pharmacists of British Columbia made pursuant to these Acts. PODSA bylaws: "Responsibilities of the Pharmacy Managers, Owne |
| Date | (Pharmacy Manager) |



HOSPITAL PHARMACY LICENCE RENEWAL

Date

Pharmacy Manager Pharmacy Address City Prov Postal Code

Dear Pharmacy Manager,

Pharmacy Licensure Expiry:

Enclosed please find your Pharmacy Licence Renewal Notice. Note that all fields of information are mandatory. Terms of a pharmacy licence renewal can be found in the Pharmacy Operations and Drug Scheduling Act (PODSA), section 3.

Pages 1 and 2 must be completed, signed and returned with payment. If the College does not receive your completed renewal package **on or before** your licence expiry date, your pharmacy must remain closed until the College confirms reinstatement of your pharmacy licence. Terms of reinstatement of your pharmacy licence can be found in PODSA, section 4. Please note that it is a contravention of the Pharmacy Operations and Drug Scheduling Act to operate an unlicensed pharmacy.

If you are enclosing individual pharmacist registration fees with your remittance, include each individual Pharmacist Registration Renewal Notice so we can track whose fees are covered by the payments

If you have any questions or comments, please feel free to contact:

Doris Wong
Administrative Assistant - Renewals & Records
(604) 676-4224 or doris.wong@bcpharmacists.org

Yours truly,

Registrar

| ID # | • |
|-------------------------|---|
| Pharmacare # | • |
| Current licence expires | |

| | PHARMACY |
|--|---|
| (Pharmacy Manager) PHARMACY Address City, Prov Postal Code | Tel: * Fax: * Email: * * required information - please provide update |

| | HEALTH AUTHORITY |
|--------------------------|------------------|
| Name of Health Authority | |
| | |
| | |

| Pharmacy licence | e fee | \$1,181.25 | +\$ 5 | 59.06 =\$ | 1,240 | .31 | | \$ | 1,240.31 |
|---|-------------------------|----------------------|----------|-----------------|-------|----------|-----|----------|----------|
| Pharmacist regist | ration (optiona | p | | | | | | | |
| Full Pharmacist regis | stration fee | \$630.00 | + | \$31.50 | = \$ | \$661.50 | 2 | X | = \$ |
| Full Pharmacist regis with building assess | | \$682.50 | + | \$34.13 | = | \$716.63 | ""X | = \$ | |
| | | | | | | | | | |
| Non-Practising Pharr | macist registration fo | ee \$504.00 - | ⊦ | \$2 Á È0 | М \$ | \$529.20 | X | _ = \$ _ | |
| Non-Practising Pharr | macist registration f | ree \$504.00₁ | - | \$ 2 Á E | M \$ | | X | | |
| Payment option | macist registration for | | | | M : | | | | |
| Payment option | order (payable to | | | | M \$ | | | | |
| Payment option Cheque/Money VISA | order (payable to | College of Pharm | acists | s of BC) | | | | | |

Please return this notice with payment



HOSPITAL PHARMACY LICENCE RENEWAL NOTICE

| ID # | |
|-------------------------|--|
| Pharmacare # | |
| Current licence expires | |

| STAFF PHA | ARMACISTS | | |
|---|--------------------------|--------------------|-----------------|
| Name Reg # Status Renewed To | Name | Reg # Sta | atus Renewed To |
| | | | |
| | | | |
| | | | |
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| | | | |
| | | | |
| Add Pharmacists not listed above in the following table | . Attach additional shee | et if necessary | |
| Name | Reg # | Full time Part tim | e Casual |
| | | | |
| | | | |
| | | | |
| | | | |

\square I attest that:

- The Pharmacy is in compliance with the Health Professions Act (HPA), the Pharmacy Operations and Drug Scheduling Act (PODSA), the Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.
- I understand my obligations as described in Part I of the PODSA bylaws: "Responsibilities of the Pharmacy Managers, Owners and Directors."

| Date | (Pharmacy Manager) | |
|------|--------------------|--|



Registrar

EDUCATION SITE LICENCE RENEWAL

| | Date |
|---|--------------------|
| Pharmacy Manager Pharmacy Address City, Prov Postal Code | |
| Dear Pharmacy Manager, Education Site Licensure Expiry: | • |
| Dear Pharmacy Manager, | |
| Education Site Licensure Expiry: | |
| Enclosed please find your Education Site Licence Renewal Notice. Note that information are mandatory. Terms of an Education Site licence renewal can Bylaws of the Pharmacy Operations and Drug Scheduling Act (PODSA), sec | n be found in the |
| Pages 1 and 2 must be completed, signed and returned with payment on or licence expiry date. | r before your |
| If you are enclosing individual pharmacist registration fees with your remitted individual Pharmacist Registration Renewal Notice so we can track whose feethe payments. | ance, include each |
| If you have any questions or comments, please-feel free to contact: | |
| Doris Wong Administrative Assistant - Renewals & Records (604) 676-4224 or doris.wong@bcpharmacists.org | |
| Yours truly, | |



| ID# | |
|-------------------------|--|
| Pharmacare # | |
| Current licence expires | |

| PHARMACY | | | | |
|------------------|--|--|--|--|
| | | | | |
| Pharmacy Manager | | | | |
| Pharmacy | Tel: * | | | |
| | Fax: * | | | |
| 3.5,, | Email: * | | | |
| | | | | |
| | * required information - please provide update | | | |
| | Fax: * Email: * | | | |

| | SITE OWNER |
|--------------------|------------|
| Name of Site Owner | |
| | |

| | PAYMENT AD | TOTAL | | |
|---|-------------------------------|------------|---------------|------------|
| Pharmacy Hicence fee | \$315.00 + \$15.75 = | \$3' \$.+) | | \$3' \$.+) |
| Pharmacist registration (option | na() | | | |
| Full Pharmacist registration fee | \$630.00 + \$31.50 = | \$661.50 | X = | \$ |
| Full Pharmacist registration fee with building assessment | \$682.50 + \$34.13 = | \$716.63 | X = | \$ |
| Non-Practising Pharmacist registration | fee \$504.00 + \$25.20 = | \$529.20 | X = | \$ |
| Payment option | | | Total payment | \$ |
| ☐ Cheque/Money order (payable to | College of Pharmacists of BC) | | _ | |
| □ VISA □ MasterCard | I | | | |
| Card # | Exp | / | | |
| | | | | |
| Cardholder | | | | |

Please return this notice with payment



| ID# | |
|-------------------------|--|
| Pharmacare # | |
| Current licence expires | |

| STAFF PHARMACISTS | | | | |
|---|---------|---------------------|-----------------|--|
| Name Reg # Status Renewed | To Name | Reg # Stati | us Renewed ToBB | |
| Add Pharmacists not listed above in the following t | | et if necessary | | |
| Name | Reg # | Full time Part time | Casual | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

\square I attest that:

- The Pharmacy is in compliance with the Health Professions Act (HPA), the Pharmacy Operations and Drug Scheduling Act (PODSA), the Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.
- I understand my obligations as described in Part I of the PODSA bylaws: "Responsibilities of the Pharmacy Managers, Owners and Directors."

| Date | (Pharmacy Manager) |
|------|--------------------|