

To apply for Full Pharmacist Registration, complete this form and initial on each page on the bottom right corner, then submit it along with the required documents to the College's Registration Department by email at: [registration@bcpharmacists.org](mailto:registration@bcpharmacists.org) or by fax at: 604-733-2493. Ensure all documents are scanned in accordance with the College's [Scanning Guidelines and Checklist for Document Submissions](#) prior to submission.

1. APPLICANT INFORMATION		
eServices ID	<input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	
Legal Last Name (Surname)	Legal First Name	Legal Middle Name
Informal Name (if any)	Gender	Date of Birth (MMM-DD-YYYY)

2. CONTACT INFORMATION		
Street Address (Include Unit/Suite #)		City
Province	Postal Code	Country
Phone Number (Home)	Phone Number (Work)	Email

3. REGISTRATION WITH OTHER REGULATORY BODIES			
Are you currently or have you ever been registered/licensed as a health professional in any jurisdiction?			
<input type="checkbox"/> No <input type="checkbox"/> Yes – complete table below (attach a separate page if more space is needed)			
Country	Name of Regulatory Body	Currently Registered (Y/N)	Last Day of Registration/Licence

Note: You are responsible for contacting the above regulatory bodies to request that your Letter of Standing (LOS) is sent directly to the College. Your LOS's must be dated no earlier than 3 months from the date you submit this application. If the LOS previously submitted to the College has expired, you must request a new one from your other regulatory body(ies) to be sent directly to the College.

If your previously submitted notarized affidavit has expired, obtain a new one and submit it to the College. See this [document](#) for templates.

4. STATUTORY DECLARATION (FORM 5)		
I declare that the following and the facts set out herein to be true ( <i>check the appropriate boxes</i> ):		
<input type="checkbox"/>	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.
<input type="checkbox"/>	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.
<input type="checkbox"/>	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.

The College of Pharmacists of BC ("College") collects, uses, discloses, stores, and retains personal information in compliance with the *Health Professions Act (HPA)*, the *Pharmacy Operations and Drug Scheduling Act (PODSA)*, and the *Freedom of Information and Protection of Privacy Act (FIPPA)*. The personal information you provide when completing and submitting this form is being collected and will be used by the College to carry out its mandate under the HPA in the public interest. The collection of this personal information is permitted under section 26(c) and (e) of FIPPA. If you have any questions or concerns about the College's privacy practices, please contact the College's Privacy Officer: [privacy@bcpharmacists.org](mailto:privacy@bcpharmacists.org) or 604.733.2440.

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<input type="checkbox"/>	4.	My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make my registration contrary to the public interest.
<input type="checkbox"/>	5.	I am a person of good character.
<input type="checkbox"/>	6.	I am aware of and will practice at all times in compliance with the <i>Health Professions Act</i> and the <i>Pharmacy Operations and Drug Scheduling Act of British Columbia</i> , the <i>Pharmacists Regulation</i> and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.
<input type="checkbox"/>	7.	<p>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:</p> <ul style="list-style-type: none"> <li>• a charge relating to an offence 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;</li> <li>• a finding of guilt in relation to an offence 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;</li> <li>• a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;</li> <li>• a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.</li> </ul>

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:

- Criminal offence/Disciplinary action/Investigation
- Date when offence was committed/Applicable health profession/Applicable jurisdiction
- Disposition of charge including details of penalty-imposed
- Extenuating circumstances you wish taken into account for your application.

## 5. CRIMINAL RECORD CHECK CONSENT

Under the Health Professions Act (HPA), all registrants of the College of Pharmacists of B.C. and all pharmacists and pharmacy technicians applying for registration are required to consent to an initial and an ongoing criminal record check (CRC) at least once every 5 years.

Every applicant and registrant must provide consent for the CRC. An applicant or registrant who refuses to provide consent will not be able to register, renew or reinstate their registration. Without registration, an individual cannot practise as a pharmacist or pharmacy technician in B.C. More information can be found on the College website at: <https://www.bcpharmacists.org/criminal-record-check>.

This information listed below as well as that listed in section 1 of this application will be used to conduct a check for records of criminal charges and convictions for any relevant or specified offence(s) under the *Criminal Records Review Act (CRRRA)*, and is collected under the authority of the CRRRA and in the case of child care facilities, the *Community Care and Assisted Living Act*, and the regulations which govern both these acts. The information provided will be used to fulfill the requirements of the CRRRA for the release of criminal records information and is in compliance with the *Freedom of Information and Protection of Privacy Act (FOIPPA)*.

Birthplace Country	Birthplace City	BC Driver's Licence (DL#) or BC Identity Card (BC ID#)
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### OTHER NAMES USED OR HAVE USED (E.G. MAIDEN NAME, BIRTH NAME, PREVIOUS MARRIED NAME, INFORMAL NAME)

You should include all\* previous names, alias names or other names that has been used by you in the past. Attach a separate paper if more space is needed.

First Name	Middle Name	Surname/Last Name

### Consent for Release of Information and Acknowledgement

Review the Consent for Release of Information and Acknowledgement and provide your consent by checking the boxes below. Click the link or copy and paste the link into your browser to view the document: [http://library.bcpharmacists.org/3\\_Registration\\_Licensure/5144-CRC\\_Consent\\_Release\\_Information\\_Acknowledgement.pdf](http://library.bcpharmacists.org/3_Registration_Licensure/5144-CRC_Consent_Release_Information_Acknowledgement.pdf). Contact the Registration Department at: [Registration@bcpharmacists.org](mailto:Registration@bcpharmacists.org) if you cannot access the document.

Please check the boxes below:

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<input type="checkbox"/>	I have read and understood the Consent for Release of Information and Acknowledgement above. I hereby consent to these terms as indicated by checking this box.
<input type="checkbox"/>	I hereby authorize the College of Pharmacists of British Columbia to conduct criminal record checks on an ongoing basis at least once every five years. I understand that I may withdraw this consent for future criminal record checks.

## 6. CONFIDENTIALITY UNDERTAKING

Under the HPA bylaws, a registrant is obligated to protect personal information under their custody. Complete the confidentiality undertaking below. I agree to access PharmaNet clinical and patient database through the in-pharmacy computer system, on the following terms and conditions:

<input type="checkbox"/>	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.
<input type="checkbox"/>	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.
<input type="checkbox"/>	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.
<input type="checkbox"/>	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.
<input type="checkbox"/>	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 Pharmacist 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.

## 7. PROFESSIONAL LIABILITY INSURANCE

In order to be granted full registration, you must meet the professional liability insurance requirements under section 81 of the HPA Bylaws.

- 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 registrant's name, the group policy covers the registrant as an individual.

<input type="checkbox"/>	I declare that I have professional liability insurance that meets all the criteria above.
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## 8. OTHER INFORMATION

I attest that:

<input type="checkbox"/>	I understand that I must comply with all applicable duties imposed under the <i>Pharmacy Operations and Drug Scheduling Act (PODSA)</i> , the <i>Health Professions Act</i> , the regulations and the bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts and any subsequent amendments.
<input type="checkbox"/>	I declare the facts set out here in this application to be true.

<b>Applicant Signature</b>	<b>Date (MMM-DD-YYYY)</b>
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9. PAYMENT INFORMATION		
Applicant Name (Full Legal Name)		
Method of Payment*: <input type="checkbox"/> Bank Draft/Money order (payable to College of Pharmacists of BC) <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard		
Card Number	Expiry Date (MM-YY)	For the Full Pharmacist Registration fee, refer to <a href="#">Schedule D – Fee Schedule</a> . This fee is subject to GST (5%). Proration may apply, therefore refer to Appendix A of the Fee Schedule. A criminal record check fee is required, where applicable.  GST # R106953920
Cardholder Name		
Cardholder Signature		

\*Acceptable methods of payment are Visa or Mastercard credit cards (Visa or Mastercard debit cards and prepaid credit cards are not accepted)

**All fees are non-refundable.**

<b><u>For office use ONLY</u></b>
iMIS ID: _____ Finance stamp: _____
Reg initials: _____
Date to Finance: _____

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