

PART A: Complete Part A and submit to the College no later than 30 days before the proposed relocation date.

1. PHARMACY INFORMATION				
Operating Name		External Signage Name		Pharmacy Licence Number
Manager Name				Manager's Licence Number (BC)
CURRENT INFORMATION				
Current Pharmacy Address			City	Province BC
Postal Code				
Email Address	Phone Number	Fax Number	Expected Closing Date	
			MMM DD YYYY	
RELOCATION INFORMATION				
New Pharmacy Address			City	Province BC
Postal Code				
Email Address	<input type="checkbox"/> No Change	Phone Number	<input type="checkbox"/> No Change	Fax Number
			<input type="checkbox"/> No Change	Expected Licensing Date
				MMM DD YYYY
Compounding Services Provided				
<input type="checkbox"/> Non-Sterile Preparation <input type="checkbox"/> Sterile, Non-Hazardous <input type="checkbox"/> Sterile, Hazardous <input type="checkbox"/> N/A				

2. APPLICANT (DIRECT OWNER) INFORMATION	
Name of Authorized Representative	Position/Title of Authorized Representative
Email Address	Phone Number
Signature	Date
	MMM DD YYYY

PART B: Complete Part B and submit to the College with photos no later than 14 days after the relocation date.

3. CONFIRMATION OF TRANSFER OF ITEMS FROM THE OLD LOCATION					
<input type="checkbox"/> I have transferred the following items from the old location to the new location on (date): _____: <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> Prescription drugs (including controlled drug substances)</td> <td><input type="checkbox"/> Medical devices (e.g. blood pressure monitors, blood glucose meters)</td> </tr> <tr> <td><input type="checkbox"/> Non-prescription drugs (including exempted codeine products)</td> <td><input type="checkbox"/> Patient medication records and prescription records</td> </tr> </table>		<input type="checkbox"/> Prescription drugs (including controlled drug substances)	<input type="checkbox"/> Medical devices (e.g. blood pressure monitors, blood glucose meters)	<input type="checkbox"/> Non-prescription drugs (including exempted codeine products)	<input type="checkbox"/> Patient medication records and prescription records
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<input type="checkbox"/> Non-prescription drugs (including exempted codeine products)	<input type="checkbox"/> Patient medication records and prescription records				
<input type="checkbox"/> I have completed narcotic counts and reconciliations as per PODSA bylaws Part 3: Section 23.8 when the old location closed.					
<input type="checkbox"/> I have provided photo(s) to confirm that all exterior signs and advertisements have been removed from the old location.					
Manager Name	Manager's Licence Number				
Signature of Manager	Date				
	MMM DD YYYY				

The College of Pharmacists of BC ("College") collects, uses, discloses, stores, and retains personal information in compliance with the *Health Professions and Occupations Act (HPOA)*, 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 HPOA 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 or 604.733.2440.



4. PAYMENT INFORMATION

Operating Name (Auto-populate)			
Method of Payment* <input type="checkbox"/> Cheque/Money order (payable to College of Pharmacists of BC) <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard			
Card Number	Expiry Date (MM/YY)		Application fee \$ 1341.00
Cardholder Name			GST \$ 67.05
Cardholder Signature			Total \$ 1408.05
			GST # R106953920

*Visa or Mastercard debit cards and prepaid credit cards are not accepted

All fees are non-refundable.

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