



1. CURRENT PHARMACY INFORMATION

Operating Name	External Signage Name	Pharmacy Licence Number	
Pharmacy Address	City	Province BC	Postal Code
Email Address	Phone Number	Fax Number	
Manager Name		Manager's Registration Number (BC)	

2. CURRENT DIRECT OWNER INFORMATION

Name of Current Direct Owner (e.g. Corporation/Sole Proprietorship/Partnership of Pharmacists)	Incorporation Number (if applicable)
Name of Current Authorized Representative	eServices ID/Registration Number (BC)
<input type="checkbox"/> I confirm that the pharmacy named above will be owned by the new direct owner on the effective date (information listed in section 3).	
Signature of Current Authorized Representative	Sign Date MMM DD YYYY

3. NEW DIRECT OWNER INFORMATION

Effective Date of Change (MMM-DD-YYYY)

Type of Ownership

Corporation: Non-Publicly Traded **or** Publicly Traded
 "Name of Company" on BC incorporation documents: _____
 BC Incorporation Number: _____ Incorporation Date: _____

Sole Proprietorship (Single pharmacist, unincorporated)
 Pharmacist's legal name: First name _____ Last name _____ Registration number (BC): _____
 Registered business name (if applicable): _____

Partnership of Pharmacists (≥ 2 pharmacists, unincorporated): Total number of partners: _____
 Each pharmacist's full legal name and registration number (BC): _____
 Registered business name (if applicable): _____

Other – Specify: _____

[?] Click on the link for more information

4. ADDITIONAL INFORMATION

As a result of this change (direct owner):

a) Will the manager be changed at the same time?	<input type="checkbox"/> Yes – Complete Form 8C	<input type="checkbox"/> No
b) Will the pharmacy operating name or external signage name be changed at the same time?	<input type="checkbox"/> Yes – Complete Form 8E	<input type="checkbox"/> No
c) Will the pharmacy layout be changed at the same time?	<input type="checkbox"/> Yes – Complete Form 8G	<input type="checkbox"/> No
d) Will any other pharmacies be affected by this change of direct owner?	<input type="checkbox"/> Yes – Complete Form 9	<input type="checkbox"/> No



5. PRIMARY CONTACT PERSON (NEW DIRECT OWNER) INFORMATION

Name	Position/Title	
Email Address	Phone Number	Fax Number

6. APPLICANT (NEW DIRECT OWNER) INFORMATION

Name of Authorized Representative	Position/Title of Authorized Representative	
Email Address	Phone Number	Fax Number
Signature	Date	
	MMM	DD YYYY

The College collects personal information on this application form to process the application and administer the College's related activities. The collection of this information is authorized under section 26(c) of the *Freedom of Information and Protection of Privacy Act* (the Act). The College is authorized to use this information as per section 32(a) of the Act and may also disclose information in other circumstances when authorized by the Act or other legislation. Further information regarding the collection, use and disclosure of personal information can be found in the privacy policy posted on the College website: <https://www.bcpharmacists.org/privacy>. Should you have any questions about the collection, use or disclosure of this information, please contact our Privacy Officer at: privacy@bcpharmacists.org or 604-733-2440.



7. PAYMENT INFORMATION

The total amount below is for one pharmacy. If this application applies to multiple pharmacies, the total amount will be charged for each pharmacy with the same change.

Operating Name (Auto-populate)

Method of Payment*

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

Card Number	Expiry Date (MM/YY)	Application fee	\$ 829.00
		Initial licence fee	\$ 2592.00
		GST	\$ 171.05
Cardholder Name		Total	\$ 3592.05
Cardholder Signature		GST #	R106953920

*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.

For office use ONLY

iMIS ID: _____ Finance stamp: _____

Lic initials: _____

Date to Finance: _____