College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF DIRECT OWNER

PODSA Form 8A

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 Licence Number (BC)**	

2. CURRENT DIRECT OWNER[2] INFORMATION

Name of Current Direct Owner (e.g. Corporation/Sole Proprietorship/Partnership of Pharmacy professionals)	**Incorporation Number (if applicable)**
Name of Current Authorized Representative	**eServices ID/Licence Number (BC)**

☐ 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[2] 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 pharmacy professional, unincorporated)*

Pharmacy professional's legal name: First name _____ Last name _____ Licence number (BC): _____

Registered business name (if applicable): _____

☐ *Partnership of Pharmacy professionals (≥2 pharmacy professionals, unincorporated*): Total number of partners: _____

Each pharmacy professional's full legal name and licence number (BC):

_____

Registered business name (if applicable): _____

☐ *Other* – Specify: _____

4. ADDITIONAL INFORMATION

As a result of this change (direct owner):

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

5. PRIMARY CONTACT PERSON (NEW DIRECT OWNER) INFORMATION	
Name	**Position/Title**
Email Address	**Phone Number**

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

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Following the submission of this application, you will receive an emailed invoice from CPBC with a secure payment link. Please check your SPAM/Junk folder in the event you do not receive it.

If you require assistance, please contact us at pharmacy@bcpharmacists.org.