College of Pharmacists of British Columbia

APPLICATION FOR CHANGE OF INDIRECT OWNER(S)

PODSA Form 8B

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. DEPARTING INDIRECT OWNER(S)

Type	Company/Corporation Name	Name of Indirect Owner	Pharmacist (Y/N)	Effective Date of Change
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY

*If known

3. NEW INDIRECT OWNER(S)

Type	Company/Corporation Name	Name of Indirect Owner	Pharmacist (Y/N)	Effective Date of Change
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY

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4. ADDITIONAL INFORMATION

As a result of this change (indirect owner):

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

5. APPLICANT (DIRECT OWNER) INFORMATION

Name of Authorized Representative	**Position/Title of Authorized Representative**
Email Address	**Phone Number**
Signature	**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 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 or 604.733.2440.