



1. CURRENT PHARMACY INFORMATION			
Operating Name		External Signage Name	Pharmacy Licence Number
Pharmacy Address		City	Province BC
Email Address		Phone Number	Postal Code
Manager Name		Fax Number	
		Manager's Licence Number (BC)	

2. DEPARTING INDIRECT OWNER(S)				
Type	Company/Corporation Name	Name of Indirect Owner	Pharmacy Professional (Y/N)	Effective Date of Change
<input type="checkbox"/> Director <input type="checkbox"/> Officer <input type="checkbox"/> Shareholder			<input type="checkbox"/> Y – Licence #: _____ <input type="checkbox"/> N – eServices ID*: _____	MMM   DD   YYYY
<input type="checkbox"/> Director <input type="checkbox"/> Officer <input type="checkbox"/> Shareholder			<input type="checkbox"/> Y – Licence #: _____ <input type="checkbox"/> N – eServices ID*: _____	MMM   DD   YYYY
<input type="checkbox"/> Director <input type="checkbox"/> Officer <input type="checkbox"/> Shareholder			<input type="checkbox"/> Y – Licence #: _____ <input type="checkbox"/> N – eServices ID*: _____	MMM   DD   YYYY
<input type="checkbox"/> Director <input type="checkbox"/> Officer <input type="checkbox"/> Shareholder			<input type="checkbox"/> Y – Licence #: _____ <input type="checkbox"/> N – eServices ID*: _____	MMM   DD   YYYY
<input type="checkbox"/> Director <input type="checkbox"/> Officer <input type="checkbox"/> Shareholder			<input type="checkbox"/> Y – Licence #: _____ <input type="checkbox"/> N – eServices ID*: _____	MMM   DD   YYYY

\*If known

3. NEW INDIRECT OWNER(S)				
Type	Company/Corporation Name	Name of Indirect Owner	Pharmacy Professional (Y/N)	Effective Date of Change
<input type="checkbox"/> Director <input type="checkbox"/> Officer <input type="checkbox"/> Shareholder		Name:	<input type="checkbox"/> Y – Licence #: _____ <input type="checkbox"/> N – eServices ID*: _____	MMM   DD   YYYY
		Email:		
<input type="checkbox"/> Director <input type="checkbox"/> Officer <input type="checkbox"/> Shareholder		Name:	<input type="checkbox"/> Y – Licence #: _____ <input type="checkbox"/> N – eServices ID*: _____	MMM   DD   YYYY
		Email:		
<input type="checkbox"/> Director <input type="checkbox"/> Officer <input type="checkbox"/> Shareholder		Name:	<input type="checkbox"/> Y – Licence #: _____ <input type="checkbox"/> N – eServices ID*: _____	MMM   DD   YYYY
		Email:		
<input type="checkbox"/> Director <input type="checkbox"/> Officer <input type="checkbox"/> Shareholder		Name:	<input type="checkbox"/> Y – Licence #: _____ <input type="checkbox"/> N – eServices ID*: _____	MMM   DD   YYYY
		Email:		
<input type="checkbox"/> Director <input type="checkbox"/> Officer <input type="checkbox"/> Shareholder		Name:	<input type="checkbox"/> Y – Licence #: _____ <input type="checkbox"/> N – eServices ID*: _____	MMM   DD   YYYY
		Email:		

\*If known



#### 4. ADDITIONAL INFORMATION

**As a result of this change (indirect owner):**

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

#### 5. APPLICANT (DIRECT OWNER) INFORMATION

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

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