



College of Pharmacists  
of British Columbia

**APPLICATION FOR NEW PHARMACY LICENCE**  
Pharmacy Education Site

**PODSA Form 1F**  
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**1. EDUCATION SITE INFORMATION**

|                                 |                                |   |                    |
|---------------------------------|--------------------------------|---|--------------------|
| <b>Proposed Operating Name</b>  |                                | <b>Proposed Licensure Date</b>                |                    |
|                                 |                                | MMM   | DD   YYYY          |
| <b>Pharmacy Address</b>         | <b>City</b>                    | <b>Province</b><br>BC                         | <b>Postal Code</b> |
| <b>Email Address</b>            | <b>Phone Number (if known)</b> | <b>Fax Number (if known)</b>                  |                    |
| <b>Manager Name (if known)</b>  |                                | <b>Manager's Registration Number (BC)</b>     |                    |
| <b>Program Coordinator Name</b> |                                | <b>Coordinator's Registration Number (BC)</b> |                    |

**2. DIRECT OWNER INFORMATION**

|  |             |                       |                    |
|--|-------------|-----------------------|--------------------|
| <b>Institution Name</b>  |             |                       |                    |
|  |             |                       |                    |
| <b>Institution Address (if different from the pharmacy address)</b>  | <b>City</b> | <b>Province</b><br>BC | <b>Postal Code</b> |
| <b>Type of Ownership</b>   |             |                       |                    |
| <input type="checkbox"/> Public Post-Secondary Educational Institution <input type="checkbox"/> Private Post-Secondary Educational Institution |             |                       |                    |
| <b>Program Offered</b>   |             |                       |                    |
| <input type="checkbox"/> CCAPP Accredited Pharmacy Program (Pharmacists) <input type="checkbox"/> CCAPP Accredited Pharmacy Technician Program |             |                       |                    |

**3. PRIMARY CONTACT PERSON INFORMATION**

|                      |                       |                   |
|----------------------|-----------------------|-------------------|
| <b>Name</b>          | <b>Position/Title</b> |                   |
|                      |                       |                   |
| <b>Email Address</b> | <b>Phone Number</b>   | <b>Fax Number</b> |
|                      |                       |                   |

**4. 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>Fax Number</b> |
|   |  |                   |
| <input type="checkbox"/> I attest that this pharmacy education site 1) will not have controlled drug substances, 2) will be licensed solely for the purpose of pharmacy education, and 3) will not provide pharmacy services to any person. |  |                   |
| <b>Signature</b>  | <b>Date</b>  |                   |
|   | 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.bcparmacists.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](mailto:privacy@bcpharmacists.org) or 778-330-0969.

9039-App\_New\_Pcy\_Education\_Site v2022.1 (Revised 2022-01-27)



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### 5. PAYMENT INFORMATION

**Proposed 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)**

**Cardholder Name**

**Cardholder Signature**

|                     |                  |
|---------------------|------------------|
| Application fee     | \$0.00           |
| Initial licence fee | \$ 791.00        |
| GST                 | \$ 39.55         |
| <b>Total</b>        | <b>\$ 830.55</b> |
| <br>GST #           | <br>R106953920   |

**For office use ONLY**

iMIS ID: \_\_\_\_\_ Finance stamp: \_\_\_\_\_

Lic initials: \_\_\_\_\_

Date to Finance: \_\_\_\_\_