



1. HOSPITAL PHARMACY SATELLITE INFORMATION			
Proposed Operating Name		Proposed Licensure Date	
		MMM	DD YYYY
Satellite Address	City	Province BC	Postal Code
Email Address	Phone Number	Fax Number	
PharmaNet Connection Required <input type="checkbox"/> Inpatient (Read-only access to patient records with ability to update clinical information and adverse reactions) <input type="checkbox"/> Outpatient (PharmaCare adjudication of prescriptions and update of patient records) <input type="checkbox"/> Inpatient & Outpatient (Inpatient and outpatient dispensing using the same software)			

2. DIRECT OWNER INFORMATION			
Hospital Name			
Hospital Address	City	Province BC	Postal Code
Health Authority/Organization <input type="checkbox"/> Fraser Health <input type="checkbox"/> Interior Health <input type="checkbox"/> Island Health <input type="checkbox"/> Northern Health <input type="checkbox"/> Vancouver Coastal Health <input type="checkbox"/> Provincial Health Services Authority <input type="checkbox"/> First Nations Health Authority <input type="checkbox"/> Providence Healthcare <input type="checkbox"/> Other - Specify: _____			

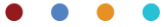
3. HOSPITAL PHARMACY (PROVIDING SERVICES TO SATELLITE) INFORMATION			
Operating Name		Pharmacy Licence Number	
Pharmacy Address	City	Province BC	Postal Code
Email Address	Phone Number	Fax Number	
Manager Name		Manager's Registration Number (BC)	

4. PRIMARY CONTACT PERSON INFORMATION	
Name	Position/Title
Email Address	Phone Number



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.



6. PAYMENT INFORMATION			
Hospital Satellite Proposed Operating Name (Auto-populate)		Central Pharmacy Operating Name (Auto-populate)	
Method of Payment* <input type="checkbox"/> Cheque/Money order (payable to College of Pharmacists of BC) <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard			
Card Number	Expiry Date (MM/YY)	Application fee	\$0.00
Cardholder Name		Annual fee	\$ 3436.00
Cardholder Signature		GST	\$ 171.80
		Total	\$ 3607.80
		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: _____	