College of Pharmacists of British Columbia

APPLICATION FOR NEW HOSPITAL PHARMACY SATELLITE

Hospital

Form 1E

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

- ☐ Inpatient (Read-only access to patient records with ability to update clinical information and adverse reactions)
- ☐ Outpatient (PharmaCare adjudication of prescriptions and update of patient records)
- ☐ Inpatient & Outpatient (Inpatient and outpatient dispensing using the same software)

2. DIRECT OWNER[2] INFORMATION

Hospital Name (where the proposed satellite will be located)			
Hospital Address (if different from the satellite address)	**City**	**Province** BC	**Postal Code**

Health Authority/Organization

☐ Fraser Health ☐ Interior Health ☐ Island Health ☐ Northern Health ☐ Vancouver Coastal Health
☐ Provincial Health Services Authority ☐ First Nations Health Authority ☐ Providence Healthcare
☐ 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

Name	**Position/Title**	
Email Address	**Phone Number**	**Fax Number**

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5. APPLICANT (DIRECT OWNER) INFORMATION

Name of Authorized Representative	**Position/Title of Authorized Representative**	
Email Address	**Phone Number**	**Fax Number**
Signature	**Date** 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.bcpharmacists.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 or 778-330-0969.

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6. PAYMENT INFORMATION

Hospital Satellite Proposed Operating Name (Auto-populate)	**Central Pharmacy 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
Annual fee	$ 791.00
GST	$ 39.55
Total	**$ 830.55**
GST #	R106953920

All fees are non-refundable.

For office use ONLY

iMIS ID: _____ Finance stamp:

Lic initials: _____

Date to Finance: _____