



The pharmacy manager and each direct/indirect owner applying/renewing for a pharmacy licence must complete this form. A new pharmacy manager or new direct/indirect owner must also complete this form as part of a change application. Only one form is required per person per pharmacy (if you have multiple roles).

1. PHARMACY INFORMATION					
[Proposed] Operating Name	Pharmacy Licence Number (if known)				
Your Relationship to the Pharmacy (Select all that apply): <table style="width: 100%; border: none;"> <tr> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> Current Pharmacy Manager <input type="checkbox"/> Proposed Pharmacy Manager </td> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> Current Indirect Owner² – Director/Officer/Shareholder of a Corporation (Subsidiary/Parent) <input type="checkbox"/> Proposed Indirect Owner² – Director/Officer/Shareholder of a Corporation (Subsidiary/Parent) </td> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> Current Direct Owner² – Sole Proprietor (Single pharmacist, unincorporated) <input type="checkbox"/> Proposed Direct Owner² – Sole Proprietor (Single pharmacist, unincorporated) </td> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> Current Direct Owner² – Pharmacist Partner (≥2 pharmacists, unincorporated) <input type="checkbox"/> Proposed Direct Owner² – Pharmacist Partner (≥2 pharmacists, unincorporated) </td> </tr> </table>		<input type="checkbox"/> Current Pharmacy Manager <input type="checkbox"/> Proposed Pharmacy Manager	<input type="checkbox"/> Current Indirect Owner ² – Director/Officer/Shareholder of a Corporation (Subsidiary/Parent) <input type="checkbox"/> Proposed Indirect Owner ² – Director/Officer/Shareholder of a Corporation (Subsidiary/Parent)	<input type="checkbox"/> Current Direct Owner ² – Sole Proprietor (Single pharmacist, unincorporated) <input type="checkbox"/> Proposed Direct Owner ² – Sole Proprietor (Single pharmacist, unincorporated)	<input type="checkbox"/> Current Direct Owner ² – Pharmacist Partner (≥2 pharmacists, unincorporated) <input type="checkbox"/> Proposed Direct Owner ² – Pharmacist Partner (≥2 pharmacists, unincorporated)
<input type="checkbox"/> Current Pharmacy Manager <input type="checkbox"/> Proposed Pharmacy Manager	<input type="checkbox"/> Current Indirect Owner ² – Director/Officer/Shareholder of a Corporation (Subsidiary/Parent) <input type="checkbox"/> Proposed Indirect Owner ² – Director/Officer/Shareholder of a Corporation (Subsidiary/Parent)	<input type="checkbox"/> Current Direct Owner ² – Sole Proprietor (Single pharmacist, unincorporated) <input type="checkbox"/> Proposed Direct Owner ² – Sole Proprietor (Single pharmacist, unincorporated)	<input type="checkbox"/> Current Direct Owner ² – Pharmacist Partner (≥2 pharmacists, unincorporated) <input type="checkbox"/> Proposed Direct Owner ² – Pharmacist Partner (≥2 pharmacists, unincorporated)		

² Click on the link for more information

2. PERSONAL INFORMATION			
<input type="checkbox"/> Dr <input type="checkbox"/> Mr <input type="checkbox"/> Ms <input type="checkbox"/> Mrs <input type="checkbox"/> Miss	Last Name	Date of Birth MMM DD YYYY	
First Name	Middle Name	Informal Name (if any)	
Address <input type="checkbox"/> Home <input type="checkbox"/> Work	City	Province	Postal Code
Country	Email Address	Phone Number	
Registration Class Are/were you a Pharmacist or Pharmacy Technician registered in BC, another province, or a foreign jurisdiction within the previous 6 years?			
<input type="checkbox"/> Yes – Complete sections 3, 4 and 5 on the next page.			
<input type="checkbox"/> No – Provide the following information and complete sections 4 and 5 on the next page (skip <u>Section 3</u>)			
a) If you have a CPBC eServices ID, enter here: _____			
b) Identification document			
i) Type of government issued ID (select any one of the following):			
<input type="checkbox"/> Canadian citizenship card/certificate			
<input type="checkbox"/> BC Identification Card			
<input type="checkbox"/> Passport Country issued: _____			
<input type="checkbox"/> Canadian driver's licence Province issued: _____			
ii) Document number of the selected document above: _____			



3. ATTESTATION FOR PHARMACISTS AND PHARMACY TECHNICIANS ONLY

Registration Information – within the previous 6 years:

I am/was a: Pharmacist Pharmacy Technician

Registered in: BC Other province: _____ Foreign jurisdiction: _____

Registration/Licence Number: _____

I attest that, within the previous 6 years:

I have never been suspended nor has my registration been cancelled by the College of Pharmacists of British Columbia, or by a body, in another province or in a foreign jurisdiction, that regulates the practice of pharmacy in that other province or foreign jurisdiction.

No limits or conditions have been imposed on my practice of pharmacy as a result of disciplinary action taken by the College of Pharmacists of British Columbia's Discipline Committee, or by a body, in another province or in a foreign jurisdiction, that regulates the practice of pharmacy in that other province or foreign jurisdiction.

NOTE: If you are unable to attest to any of the above statements, your pharmacy application will be referred to the College's Application Committee for review. The Application Committee may request additional information.

4. ATTESTATION

I attest that:

I am not authorized by an enactment to prescribe drugs².

I am not subject to a limitation imposed by the College's discipline committee that precludes me from being a direct owner, an indirect owner, or a manager.

I have never been the subject of an order or a conviction for an information or billing contravention.

I also attest that, within the previous 6 years:

I have not been convicted of an offence prescribed under section 45(1)(a)(ii) of the *Pharmaceutical Services Act*.

I have not been convicted of an offence under the *Criminal Code* (Canada).

I have not had a judgment entered against me in a court proceeding related to commercial or business activities that occurred in relation to the provision of drugs or devices, or substances or related services.

NOTE: If you are unable to attest to any of the above statements, your pharmacy application will be referred to the College's Application Committee for review. The Application Committee may request additional information.

5. DECLARATION

I understand that I must comply with all applicable duties imposed under the *Pharmacy Operations and Drug Scheduling Act (PODSA)*, the *Health Professions Act*, the regulations and the bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts and any subsequent amendments.

I declare the facts set out herein to be true.

Applicant Name (Print)	Applicant Signature	Date
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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 or 604-733-2440.