



1. INFORMATION OF THE PERSON WHO DOES NOT MEET THE ELIGIBILITY CRITERIA IN SECTION 3 OF THE ACT			
<input type="checkbox"/> Dr <input type="checkbox"/> Mr <input type="checkbox"/> Ms <input type="checkbox"/> Mrs <input type="checkbox"/> Miss		Last Name	eServices ID/Licence Number (if known)
First Name		Middle Name	Preferred Name (if any)
Name of Affiliated Organization: <input type="checkbox"/> Pharmacy Operating Name <input type="checkbox"/> Corporation Name or Name of Direct Owner			
Relationship between the Person and the Organization (Select all that apply):			
<input type="checkbox"/> Current Pharmacy Manager <input type="checkbox"/> Proposed Pharmacy Manager	<input type="checkbox"/> Current Indirect Owner <sup>2</sup> – Director/Officer/Shareholder of a Corporation (Subsidiary/Parent) <input type="checkbox"/> Proposed Indirect Owner <sup>2</sup> – Director/Officer/Shareholder of a Corporation (Subsidiary/Parent)	<input type="checkbox"/> Current Direct Owner <sup>2</sup> – Sole Proprietor (Single pharmacy professional, unincorporated) <input type="checkbox"/> Proposed Direct Owner <sup>2</sup> – Sole Proprietor (Single pharmacy professional, unincorporated)	<input type="checkbox"/> Current Direct Owner <sup>2</sup> – Partnership of pharmacy professionals (≥2 pharmacy professionals, unincorporated) <input type="checkbox"/> Proposed Direct Owner <sup>2</sup> – Partnership of pharmacy professionals (≥2 pharmacy professionals, unincorporated)

2. ADDITIONAL INFORMATION RELATED TO THE PERSON NAMED ABOVE	
Matter related to a(n):	
<input type="checkbox"/> Order or conviction <b>FOR/UNDER:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Information contravention</li> <li><input type="checkbox"/> Billing contravention</li> <li><input type="checkbox"/> Section 45(1)(a)(ii) of the <i>Pharmaceutical Services Act</i></li> <li><input type="checkbox"/> <i>Criminal Code</i> (Canada)</li> <li><input type="checkbox"/> Other – Specify: _____</li> </ul>	
<input type="checkbox"/> Suspension or cancellation of licence as a pharmacy technician or pharmacist;	
<input type="checkbox"/> Limits or conditions being imposed on (select one):	
<input type="checkbox"/> Practice of pharmacy	
<input type="checkbox"/> Being a direct owner, indirect owner, or a manager of a pharmacy	
<input type="checkbox"/> Judgement issued 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 device	
<input type="checkbox"/> Other – Specify: _____	
Description of the events that resulted in the matter above.	
Date/period the above events occurred.	



<b>Name of the entity/court/governing body that:</b> <ul style="list-style-type: none"> <li>• Issued the order or conviction</li> <li>• Suspended/cancelled billing privileges or licence as a pharmacist or pharmacy technician; OR</li> <li>• Imposed limits or conditions</li> </ul>	
<b>Date (or period, when specified) of:</b> <ul style="list-style-type: none"> <li>• Order or conviction;</li> <li>• Suspension (period) or cancellation of billing privileges or licence as a pharmacist or pharmacy technician; OR</li> <li>• Limits or conditions being imposed</li> </ul>	
<b>Disposition of charge including details of penalty-imposed (e.g. fine, imprisonment, limits and conditions imposed).</b>	
<b>Extenuating circumstances you wish to be taken into account for this pharmacy application.</b>	
<b>Other</b>	

\*Attach a separate sheet if you need more space

- Without limiting the foregoing, I consent to the College using and disclosing information (including my personal information) collected or created by the College's Investigation Committee or Discipline Tribunal with the College's Application Committee as the College considers necessary for the purpose of processing an application under the *Pharmacy Operations and Drug Scheduling Act*.

3. INFORMATION OF THE PERSON WHO COMPLETED THIS FORM		
<b>Name</b>	<b>Signature</b>	<b>Date</b> MMM   DD   YYYY
<b>Email</b>	<b>Phone Number</b>	
<b>Relationship to the Pharmacy:</b> <input type="checkbox"/> Current Direct/Indirect Owner <input type="checkbox"/> Current Pharmacy Manager <input type="checkbox"/> Other: _____ <input type="checkbox"/> Proposed Direct/Indirect Owner <input type="checkbox"/> Proposed Pharmacy Manager		

The College of Pharmacists of BC ("College") collects, uses, discloses, stores, and retains personal information in compliance with the *Health Professions and Occupations Act (HPOA)*, 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 HPOA 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](mailto:privacy@bcpharmacists.org) or 604.733.2440.