



College of Pharmacists  
of British Columbia

# APPLICATION FOR CHANGE OF AUTHORIZED REPRESENTATIVE(S)

L-Form 13

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This form is to be used by direct owners that are **NOT** corporations. If the direct owner is a corporation, submit the *Change of Indirect Owner* application on eServices (note: must be submitted by a current director of the corporation) – visit the [College website](#) for more information.

1. CURRENT PHARMACY 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)	

2. DEPARTING AUTHORIZED REPRESENTATIVE(S)		
Name	Pharmacist (Y/N)	Effective Date of Change
	<input type="checkbox"/> Y – Registration #: _____ <input type="checkbox"/> N – eServices ID*: _____	MMM   DD   YYYY
	<input type="checkbox"/> Y – Registration #: _____ <input type="checkbox"/> N – eServices ID*: _____	MMM   DD   YYYY
	<input type="checkbox"/> Y – Registration #: _____ <input type="checkbox"/> N – eServices ID*: _____	MMM   DD   YYYY

\*If known

3. NEW AUTHORIZED REPRESENTATIVE(S)			
Name	Email	Pharmacist (Y/N)	Effective Date of Change
		<input type="checkbox"/> Y – Registration #: _____ <input type="checkbox"/> N – eServices ID*: _____	MMM   DD   YYYY
		<input type="checkbox"/> Y – Registration #: _____ <input type="checkbox"/> N – eServices ID*: _____	MMM   DD   YYYY
		<input type="checkbox"/> Y – Registration #: _____ <input type="checkbox"/> N – eServices ID*: _____	MMM   DD   YYYY

\*If known

4. ADDITIONAL INFORMATION			
a)	As a result of this change (authorized representative), will <b>other pharmacies</b> be affected by the same change?	<input type="checkbox"/> Yes – Also complete <a href="#">Form 9</a>	<input type="checkbox"/> No
b)	Is the departing authorized representative also the manager of the pharmacy and is departing from the role of manager as well?	<input type="checkbox"/> Yes – Also complete <a href="#">Form 8C</a>	<input type="checkbox"/> No

5. APPLICANT (DIRECT OWNER) INFORMATION		
Name of Authorized Representative	Position/Title of Authorized Representative	
Email Address	Phone Number	Fax Number
Signature	Sign 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](mailto:privacy@bcpharmacists.org) or 778-330-0969.