



College of Pharmacists
of British Columbia

Request for Access to Records

You may make a request for access to records without using this form, provided you do so in writing via email to: FOI@bcpharmacists and provide the same information requested below. Personal information contained on this form is collected under the *Freedom of Information and Protection of Privacy Act* and will be used only for the purpose of responding to your request.

Application Fee for General Requests (non-refundable): \$10 per request (no fees for personal FOI requests). For general requests there may be additional processing fees. You will be contacted with an estimate of the processing fee.

CONTACT INFORMATION (all fields required)				
Last Name		First Name	Business/Organization Name (if applicable)	
Street, Apt.#, PO Box, RR No.		City/Town	Prov	Postal Code
Phone	Email Address			
DETAILS OF REQUESTED INFORMATION				
Please be as specific and detailed as possible as this will assist the request process (include date range, file #s, etc.). Attach a separate sheet, if the space below is not sufficient. Request Category: <input type="checkbox"/> Access to General Information <u>or</u> <input type="checkbox"/> Access to Personal Information				
Are you requesting access to another person's personal information? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please attach, as appropriate: a) That person's signed consent for disclosure, or b) Proof of authority to act on that person's behalf				
Please advise how you would like to receive the records you are requesting. Note that we are unable to courier to a PO box address and a signature will be required upon delivery. <input type="checkbox"/> Electronic records by email <input type="checkbox"/> Paper records by mail (photocopying fees may be applicable)				
Your signature		Date signed: YYYY/MM/DD		
FOR COLLEGE USE ONLY				
Request No.				
FOI Officer Signature		Date received: YYYY/MM/DD		



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PAYMENT INFORMATION			
Applicant Name			
Method of Payment: <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard			
Card Number	Expiry Date (MM-YY)	FOI Application fee	\$ 10.00
		GST	\$ 0.00
Cardholder Name		Total	\$ 10.00
Cardholder Signature		GST #	R106953920

For office use ONLY

Submitted by: _____

Date to Finance: _____

Finance Stamp: