COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA
Safe and Effective Pharmacy Care

Board Meeting Minutes **February 1, 2013**
Via Teleconference

Present:

Doug Kipp, Chair, District 4 Board Member
Beverley Harris, Vice-Chair, District 2 Board Member
Robert Craigue, District 5 Board Member
Jerry Casanova, District 7 Board Member
Kris Gustavson, Board Member
Ryan Hoag, Board Member
Jeff Slater, Board Member
Jeremy Walden, Board Member

Regrets:

Agnes Fridl Poljak, District 1 Board Member
Blair Tymchuk, District 3 Board Member
Anar Dossa, District 6 Board Member
Bal Dhillon, District 8 Board Member

Staff:

Bob Nakagawa, Registrar
Lori Tanaka, Executive Assistant to the Deputy Registrar
Pina Naccarato, Executive Assistant to the Registrar (Minute Taker)

1. WELCOME AND CALL TO ORDER

Meeting convened at 1:00 pm.

- The Chair turned the meeting over to the Registrar to present the proposed bylaw changes as identified in the pre-circulated documents.

2. RESCIND 2 RESOLUTIONS, INCLUDING THEIR RELEVANT SCHEDULES, FROM THE MEETING OF JANUARY 24, 2013

It was moved (R. Craigue), seconded (B. Harris) that the following resolutions be rescinded:

a) in accordance with the authority established in section 19(1) of the Health Professions Act, and subject to filing with the Minister as required by section 19(3) of the Health Professions Act, the board amend the bylaws of the College of Pharmacists of British Columbia, as set out in the schedule attached to this resolution. (Below, Resolution A)

b) in accordance with the authority established in section 21(1) of the Pharmacy Operations and Drug Scheduling Act, and subject to filing with the Minister as required by section 21(4) of the Pharmacy Operations and Drug Scheduling Act, the board amend the bylaws of the College of Pharmacists of British Columbia, as set out in the schedule attached to this resolution. (Below, Resolution B)

The motion was CARRIED

Resolution A
SCHEDULE

The bylaws of the College of Pharmacists of British Columbia made under the authority of the *Health Professions Act* are amended by repealing Forms 4, 6, 7, 8, 10, 11 and 13, and Schedule D and substituting the attached new Forms 4, 6, 7, 8, 10, 11 and 13 and Schedule D.

Resolution B
SCHEDULE

The bylaws of the College of Pharmacists of British Columbia made under the authority of the *Pharmacy Operations and Drug Scheduling Act* are amended by repealing Forms 1 through 6 and Schedule A and substituting the attached new Forms 1 through 6 and Schedule A.

3. BYLAW FORMS FOR FILING WITH THE MINISTER OF HEALTH

DISCUSSION POINTS:

- The Registrar presented the following resolutions to have the HST replaced with the GST on the College forms.

It was moved (J. Slater), seconded (B. Harris) that the following resolution be approved:

a) in accordance with the authority established in section 19(1) of the *Health Professions Act*, and subject to filing with the Minister as required by section 19(3) of the *Health Professions Act*, the board amend the bylaws of the College of Pharmacists of British Columbia, as set out in the schedule attached to this resolution.

The motion was CARRIED

It was moved (R. Craigue), seconded (J. Slater) that the following resolution be approved:

b) in accordance with the authority established in section 21(1) of the Pharmacy Operations and Drug Scheduling Act, and subject to filing with the Minister as required by section 21(4) of the Pharmacy Operations and Drug Scheduling Act, the board amend the bylaws of the College of Pharmacists of British Columbia, as set out in the schedule attached to this resolution.

The motion was CARRIED

3. ADJOURNMENT

The Board Meeting adjourned at 1:05 pm.

APPLICATION FOR
FULL PHARMACIST REGISTRATION

APPLICANT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Name _____
Last name (Surname) *First name* *Other name(s)*

Address _____ Tel *(home)* _____

_____ Tel *(work)* _____

_____ Email _____
City *Province*

_____
Postal code *Country*

PAYMENT OPTION

☐ Cheque/Money order (*payable to College of Pharmacists of BC*)

☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Registration fee	682.50
GST	34.13
Total	**$716.63**

GST # R106953920

I attest that I am in compliance with the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

I have professional liability insurance that meets the following criteria *(please check the box(es) below):*

- ☐ Provides a minimum of $2 million coverage.
- ☐ Provides occurrence based coverage or claims made with extended reporting period of at least 3 years.
- ☐ If not in the pharmacist's name, the group policy covers the pharmacist as an individual.

I have signed and attached *(please check the box(es) below)*:

- ☐ Statutory Declaration *(use form on page 2).*
- ☐ Pharmacists Confidentiality Undertaking *(use form on page 3).*

_____ _____
Date Applicant signature

APPLICATION FOR

FULL PHARMACIST REGISTRATION

Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)* :

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC.

- *a charge relating to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs, or relating to any criminal offense;*
- *a finding of guilt in relation to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above is not true (i.e. if any of the above boxes is not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

_____ Date

_____ Applicant signature

APPLICATION FOR

FULL PHARMACIST REGISTRATION

Pharmacist Confidentiality Undertaking

I agree to access the **PharmaNet** clinical and patient database through the in-pharmacy computer system, on the following terms and conditions:

- ☐ I will not access or use any clinical or patient information in the PharmaNet database or the in-Pharmacy computer system for any purpose other than those authorized by the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act and the Bylaws of the College of Pharmacists of BC made pursuant to these Acts.

- ☐ I agree at all times to treat as confidential all information referred to in paragraph (1) and will not participate in or permit, the unauthorized release, publication or disclosure of the said information to any person, corporation or other entity under any circumstances except as authorized by the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act and the Bylaws of the College of Pharmacists of BC made pursuant to these Acts.

- ☐ I agree at all times, to treat as confidential all information relating to the security and management of the PharmaNet database and the in-pharmacy computer system.

- ☐ I agree to be bound by the provisions of this agreement and will continue to do so following termination of employment in the pharmacy for any reason.

- ☐ I agree to adhere to all policies and procedures issued by the pharmacy manager and/or the pharmacy owner, consistent with legislation, policies, procedures and standards issued by the College of Pharmacists of British Columbia or the Province of British Columbia, related to the confidentiality, privacy and security of the patient or clinical information contained in the PharmaNet database and the in-pharmacy computer database.

_____ Date

_____ Applicant signature

Note:

1. *Attach original with application for registration.*
2. *Make a copy for the pharmacy manager - to be retained in the pharmacy files.*

APPLICATION FOR
LIMITED PHARMACIST REGISTRATION

APPLICANT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Name _____
Last name (Surname) *First name* *Other name(s)*

Address _____ Tel *(home)* _____

_____ Tel *(work)* _____

_____ Email _____
City *Province*

_____
Postal code *Country*

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Registration fee	682.50
GST	34.13
Total	**$716.63**

GST # R106953920

I attest that I am in compliance with the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

I have professional liability insurance that meets the following criteria:

- ☐ Provides a minimum of $2 million coverage.
- ☐ Provides occurrence based coverage or claims made with extended reporting period of at least 3 years.
- ☐ If not in the pharmacists' name, the group policy covers the pharmacist as an individual.

I have signed and attached:

- ☐ Statutory Declaration *(use form on page 2).*
- ☐ Pharmacists Confidentiality Undertaking *(use form on page 3).*

_____ _____
Date Applicant signature

APPLICATION FOR

LIMITED PHARMACIST REGISTRATION

Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)* :

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC.

- *a charge relating to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs, or relating to any criminal offense;*
- *a finding of guilt in relation to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above is not true (i.e. if any of the above boxes is not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

_____ Date

_____ Applicant signature

APPLICATION FOR

LIMITED PHARMACIST REGISTRATION

Pharmacist Confidentiality Undertaking

I agree to access the **PharmaNet** clinical and patient database through the in-pharmacy computer system, on the following terms and conditions:

- ☐ I will not access or use any clinical or patient information in the PharmaNet database or the in-Pharmacy computer system for any purpose other than those authorized by the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act and the Bylaws of the College of Pharmacists of BC made pursuant to these Acts.

- ☐ I agree at all times to treat as confidential all information referred to in paragraph (1) and will not participate in or permit, the unauthorized release, publication or disclosure of the said information to any person, corporation or other entity under any circumstances except as authorized by the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act and the Bylaws of the College of Pharmacists of BC made pursuant to these Acts.

- ☐ I agree at all times, to treat as confidential all information relating to the security and management of the PharmaNet database and the in-pharmacy computer system.

- ☐ I agree to be bound by the provisions of this agreement and will continue to do so following termination of employment in the pharmacy for any reason.

- ☐ I agree to adhere to all policies and procedures issued by the pharmacy manager and/or the pharmacy owner, consistent with legislation, policies, procedures and standards issued by the College of Pharmacists of British Columbia or the Province of British Columbia, related to the confidentiality, privacy and security of the patient or clinical information contained in the PharmaNet database and the in-pharmacy computer database.

_____ Date

_____ Applicant signature

Note:

1. *Attach original with application for registration.*
2. *Make a copy for the pharmacy manager - to be retained in the pharmacy files.*

APPLICATION FOR PRE-REGISTRATION

CANADA – AGREEMENT ON INTERNAL TRADE (AIT)

CHECKLIST

You must submit

1. ☐ Checklist *(page 1)*.
2. ☐ Application form *(page 2)*.
3. ☐ Copy of birth certificate or Canadian citizenship card.
4. ☐ Copy of university degree(s).
5. ☐ Letter of current standing to be mailed to College office directly from applicant's existing regulatory authorities. Letter must be dated within three months prior to the date of the application.
6. ☐ Notarized identification *(use form on page 3)*.
7. ☐ Declaration of currency with legislation and practice standards *(use form on page 4)*.
8. ☐ Statutory declaration *(use form on page 5)*.
9. ☐ Criminal record check authorization *(use form on page 6)*.

You must submit IF

10. ☐ Copy of PEBC certification - if applicable.
11. ☐ Copy of name change or marriage certificate - if name on any document is different from legal name.
12. ☐ Evidence of your authorization to work in Canada – if you are not a Canadian citizen or a permanent resident. Acceptable documents: Canadian citizenship card, Canadian passport, permanent resident card, social insurance card, or work permit.
13. ☐ A letter/certificate of standing from **each** regulatory body - if you have engaged in the practice of pharmacy or another health profession in a Canadian or foreign jurisdiction. Letter/certificate must be dated within three months prior to the date of the application and must be mailed to the college office directly from the regulatory bodies.

Photocopy both sides of documents where applicable.
Documents in a language other than English must be translated by a government official or an official translator.

APPLICATION FOR PRE-REGISTRATION

CANADA – AGREEMENT ON INTERNAL TRADE (AIT)

Application Form

CONTACT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Address _____ Tel *(home)* _____

_____ Tel *(work)* _____

_____ Email _____
City *Province*

_____
Postal code *Country*

OTHER INFORMATION

1) Education *University/Country* _____

Degree/Year _____

2) Birth date *YYYY-MM -DD* _____ YES NO

3) Is this the first time you have applied for pre-registration with the College of Pharmacists of BC? ☐ ☐

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card #_____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Application fee *	335.00
GST	16.75
Total	**$351.75**

GST # R106953920

** Includes criminal record check*

_____ Date

_____ Applicant signature

APPLICATION FOR PRE-REGISTRATION

CANADA – AGREEMENT ON INTERNAL TRADE (AIT)

Notarized Identification

APPLICANT INFORMATION

Applicant name _____

Photo

Required Documents

Passport photograph, taken within one year, affixed to space provided.

Copy of name change or marriage certificate if name on any document is different from legal name.

Required identification - one primary and one secondary.

Identification presented to the Notary Public must be the **original** document issued by the government agency. Photocopies are acceptable only if certified by the issuing government agency to be true copies of the original.

PRIMARY		SECONDARY	
Document type	*Document number*	*Document type*	*Document number*
☐ Birth certificate		☐ Passport	
☐ Canadian citizen card		☐ Valid Canadian driver's license	
☐ Canadian identity card		☐ British Columbia identification card	
		☐ Naturalization certificate	
		☐ Canadian Forces identification	

_____ Date

_____ Applicant signature

NOTARY PUBLIC CERTIFICATION

I hereby verify that the person shown in the photograph affixed on this page is the same person:

- Whose name appears as the Applicant.
- Whose identity has been proven to my satisfaction through presentation of the identification indicated.
- Whose signature on this document was signed in my presence.

_____ Date

_____ Notary signature

Notary name _____

SEAL

Address _____

_____

Tel _____

APPLICATION FOR PRE-REGISTRATION

CANADA – AGREEMENT ON INTERNAL TRADE (AIT)

Declaration of Currency with Legislation and Practice Standards

DECLARATION

I, _____, confirm my knowledge of:

☐ The legislation defined in:

- The Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Regulation and Bylaws of the College of Pharmacists of BC made pursuant to these Acts,
- The College of Pharmacists of BC Professional Practice Policies,
- The Food & Drugs Act and Regulations, and
- The Controlled Drugs & Substances Act.

☐ The practice standards defined in the Framework of Professional Practice.

_____ Date

_____ Applicant signature

APPLICATION FOR PRE-REGISTRATION

CANADA – AGREEMENT ON INTERNAL TRADE (AIT)

Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)* :

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC.

- *a charge relating to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs, or relating to any criminal offense;*
- *a finding of guilt in relation to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above is not true (i.e. if any of the above boxes is not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

_____ _____

Date Applicant signature

APPLICATION FOR PRE-REGISTRATION

CANADA – AGREEMENT ON INTERNAL TRADE (AIT)

Criminal Record Check Authorization

APPLICANT INFORMATION

Legal name _____
Last name (Surname) First name Other name(s)

Mailing address _____
Street City/town Province/State Postal Code

_____ Contact phone _____
Country Area code

Gender ☐ Male ☐ Female B.C. Driver License _____

Birth date _____ Birthplace _____
YYYY-MM-DD City/town Province/State Country

Other names used or have used *(e.g. maiden name, birth name, previous married name)*

1. _____
Surname First name Middle name
2. _____
Surname First name Middle name
3. _____
Surname First name Middle name

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA)

The information requested on this form is collected under the authority of the Criminal Records Review Act and in the case of child care facilities, the Community Care Facility Act, and the regulations which govern both these acts. The information provided will be used to fulfill the requirements of the Criminal Records Review Act for the release of criminal records information and is in compliance with the FOIPPA.

CONSENT FOR RELEASE OF INFORMATION AND ACKNOWLEDGEMENTS

Pursuant to the B.C. *Criminal Records Review Act*

- I hereby consent to a check for records of criminal convictions to determine whether I have a conviction or outstanding charge for any relevant offences under the Criminal Records Review Act.
- I hereby authorize the release to the Deputy Registrar any documents in the custody of the police, the court and crown counsel relating to an outstanding charge or conviction of any relevant offence as defined under the Criminal Records Review Act
- Where the results of this check indicate that a criminal record or outstanding charge for a relevant offence may exist, I agree to provide my fingerprints to verify any such criminal record.
- The Deputy Registrar will notify me and my organization that I have an outstanding charge or conviction for any relevant offence(s) and the matter has been referred to the Deputy Registrar.
- The Deputy Registrar will determine whether or not I present a risk to physical or sexual abuse to children.
- The Deputy Registrar's determination will be disclosed to my organization and it will include consideration of any relevant offence for which I have received a pardon.
- If I am charged with or convicted of a relevant offence at any time subsequent to the criminal record check authorized herein, I further agree to report the charge or conviction to my organization and provide my organization, in a timely manner, with a new-signed Consent to a Criminal Record Check form.

"Deputy Registrar" means a person appointed under the Public Service Act *as deputy registrar for the purposes of this Act.*

☐ I have read and understood the Consent for Release of Information and Acknowledgements above. I hereby consent to these terms as indicated by my signature below.

☐ I hereby authorize the College of Pharmacists of British Columbia to conduct criminal record checks on an ongoing basis every five years. I understand that I may withdraw this consent for future criminal record checks.

_____ _____
Date Applicant signature

APPLICATION FOR PRE-REGISTRATION

CANADA – NON AGREEMENT ON INTERNAL TRADE (NON AIT)

CHECKLIST

You must submit

1. ☐ Checklist *(page 1)*.
2. ☐ Application form *(page 2)*.
3. ☐ Copy of birth certificate or Canadian citizenship card.
4. ☐ Copy of university degree(s).
5. ☐ Letter of current standing to be mailed to College office directly from applicant's existing regulatory authorities. Letter must be dated within one month prior to the date of the application.
6. ☐ Notarized identification *(use form on page 3)*.
7. ☐ Certification of Pharmacy Related Employment *(use form on page 4)*.
8. ☐ Statutory declaration *(use form on page 5)*.
9. ☐ Criminal record check authorization *(use form on page 6)*.

You must submit IF

10. ☐ Copy of name change or marriage certificate - if name on any document is different from legal name.
11. ☐ Copy of PEBC certification – if applicable.
12. ☐ Evidence of your authorization to work in Canada – if you are not a Canadian citizen or a permanent resident. Acceptable documents: Canadian citizenship card, Canadian passport, permanent resident card, social insurance card, or work permit.
13. ☐ A letter/certificate of standing from **each** regulatory body - if you have engaged in the practice of pharmacy or another health profession in a Canadian or foreign jurisdiction. Letter/certificate must be dated within three months prior to the date of the application and must be mailed to the college office directly from the regulatory bodies.

Photocopy both sides of documents where applicable.
Documents in a language other than English must be translated by a government official or an official translator.

APPLICATION FOR PRE-REGISTRATION

CANADA – NON AGREEMENT ON INTERNAL TRADE (NON AIT)

Application Form

CONTACT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Address _____ Tel *(home)* _____

_____ Tel *(work)* _____

_____ Email _____
City *Province*

_____
Postal code *Country*

OTHER INFORMATION

1) Education *University/Country* _____

Degree/Year _____

2) Birth date *YYYY-MM -DD* _____ YES NO

3) Is this the first time you have applied for pre-registration with the College of Pharmacists of BC? ☐ ☐

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card #_____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Application fee *	335.00
GST	16.75
Total	**$351.75**

GST # R106953920

** Includes criminal record check*

_____ Date

_____ Applicant signature

APPLICATION FOR PRE-REGISTRATION

CANADA – NON AGREEMENT ON INTERNAL TRADE (NON AIT)

Notarized Identification

APPLICANT INFORMATION

Applicant name _____

Photo

Required Documents

Passport photograph, taken within one year, affixed to space provided.

Copy of name change or marriage certificate if name on any document is different from legal name.

Required identification - one primary and one secondary.

Identification presented to the Notary Public must be the **original** document issued by the government agency. Photocopies are acceptable only if certified by the issuing government agency to be true copies of the original.

PRIMARY		SECONDARY	
Document type	*Document number*	*Document type*	*Document number*
☐ Birth certificate		☐ Passport	
☐ Canadian citizen card		☐ Valid Canadian driver's license	
☐ Canadian identity card		☐ British Columbia identification card	
		☐ Naturalization certificate	
		☐ Canadian Forces identification	

_____ Date

_____ Applicant signature

NOTARY PUBLIC CERTIFICATION

I hereby verify that the person shown in the photograph affixed on this page is the same person:

- Whose name appears as the Applicant.
- Whose identity has been proven to my satisfaction through presentation of the identification indicated.
- Whose signature on this document was signed in my presence.

_____ Date

_____ Notary signature

Notary name _____

SEAL

Address _____

_____

Tel _____

APPLICATION FOR PRE-REGISTRATION

CANADA – NON AGREEMENT ON INTERNAL TRADE (NON AIT)

Certification of Pharmacy Related Employment

EMPLOYMENT INFORMATION

Applicant name _____

Employer name _____

Address _____

_____

_____

Tel _____ Fax _____

Position _____ Total hours worked _____

Start date _____ End date _____

EMPLOYER CERTIFICATION

I certify that the above employment information is correct.

Name _____

Position _____

Pharmacy Manager / Pharmacy Owner / Human Resources Manager

_____ _____

Date Employer signature

APPLICATION FOR PRE-REGISTRATION

CANADA – NON AGREEMENT ON INTERNAL TRADE (NON AIT)

Statutory Declaration (Form 5)

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AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

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☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC.

- *a charge relating to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs, or relating to any criminal offense;*
- *a finding of guilt in relation to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above is not true (i.e. if any of the above boxes is not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

_____ Date

_____ Applicant signature

APPLICATION FOR PRE-REGISTRATION

CANADA – NON AGREEMENT ON INTERNAL TRADE (NON AIT)

Criminal Record Check Authorization

APPLICANT INFORMATION

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Mailing address _____
Street *City/town* *Province/State* *Postal Code*

_____ Contact phone _____
Country *Area code*

Gender ☐ Male ☐ Female B.C. Driver License _____

Birth date _____ Birthplace _____
YYYY-MM-DD *City/town* *Province/State* *Country*

Other names used or have used *(e.g. maiden name, birth name, previous married name)*

1. _____
Surname *First name* *Middle name*
2. _____
Surname *First name* *Middle name*
3. _____
Surname *First name* *Middle name*

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA)

The information requested on this form is collected under the authority of the Criminal Records Review Act and in the case of child care facilities, the Community Care Facility Act, and the regulations which govern both these acts. The information provided will be used to fulfill the requirements of the Criminal Records Review Act for the release of criminal records information and is in compliance with the FOIPPA.

CONSENT FOR RELEASE OF INFORMATION AND ACKNOWLEDGEMENTS

Pursuant to the B.C. *Criminal Records Review Act*

- I hereby consent to a check for records of criminal convictions to determine whether I have a conviction or outstanding charge for any relevant offences under the Criminal Records Review Act.
- I hereby authorize the release to the Deputy Registrar any documents in the custody of the police, the court and crown counsel relating to an outstanding charge or conviction of any relevant offence as defined under the Criminal Records Review Act
- Where the results of this check indicate that a criminal record or outstanding charge for a relevant offence may exist, I agree to provide my fingerprints to verify any such criminal record.
- The Deputy Registrar will notify me and my organization that I have an outstanding charge or conviction for any relevant offence(s) and the matter has been referred to the Deputy Registrar.
- The Deputy Registrar will determine whether or not I present a risk to physical or sexual abuse to children.
- The Deputy Registrar's determination will be disclosed to my organization and it will include consideration of any relevant offence for which I have received a pardon.
- If I am charged with or convicted of a relevant offence at any time subsequent to the criminal record check authorized herein, I further agree to report the charge or conviction to my organization and provide my organization, in a timely manner, with a new-signed Consent to a Criminal Record Check form.

"Deputy Registrar" means a person appointed under the Public Service Act *as deputy registrar for the purposes of this Act.*

☐ I have read and understood the Consent for Release of Information and Acknowledgements above. I hereby consent to these terms as indicated by my signature below.

☐ I hereby authorize the College of Pharmacists of British Columbia to conduct criminal record checks on an ongoing basis every five years. I understand that I may withdraw this consent for future criminal record checks.

_____ _____
Date Applicant signature

APPLICATION FOR PRE-REGISTRATION

CANADA – NEW GRADUATE

CHECKLIST

You must submit

1. ☐ Checklist *(page 1)*.
2. ☐ Application form *(page 2)*.
3. ☐ Copy of birth certificate or Canadian citizenship card.
4. ☐ Copy of university degree(s) or letter from the Dean confirming the date the degree is to be received.
5. ☐ Proof of registration for PEBC Qualifying Examinations Part I and Part II.
6. ☐ Notarized identification *(use form on page 3)*.
7. ☐ Statutory declaration *(use form on page 4)*.
8. ☐ Criminal record check authorization *(use form on page 5)*.

You must submit IF

9. ☐ Copy of name change or marriage certificate - if name on any document is different from legal name.
10. ☐ Evidence of your authorization to work in Canada – if you are not a Canadian citizen or a permanent resident. Acceptable documents: Canadian citizenship card, Canadian passport, permanent resident card, social insurance card, or work permit.
11. ☐ A letter/certificate of standing from **each** regulatory body - if you have engaged in the practice of pharmacy or another health profession in another jurisdiction. Letter/certificate must be dated within three months prior to the date of the application and must be mailed to the college office directly from the regulatory bodies.

Photocopy both sides of documents where applicable.
Documents in a language other than English must be translated by a government official or an official translator.

APPLICATION FOR PRE-REGISTRATION
CANADA – NEW GRADUATE

Application Form

CONTACT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Address _____ Tel *(home)* _____

_____ Tel *(work)* _____

_____ Email _____
City *Province*

_____ _____
Postal code *Country*

OTHER INFORMATION

1) Education *University/Country* _____

Degree/Year _____

2) Birth date *YYYY-MM -DD* _____

	YES	NO
3) Is this the first time you have applied for pre-registration with the College of Pharmacists of BC?	☐	☐

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card #_____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Application fee *	335.00
GST	16.75
Total	**$351.75**

GST # R106953920

* *Includes criminal record check*

_____ _____
Date Applicant signature

APPLICATION FOR PRE-REGISTRATION

CANADA – NEW GRADUATE

Notarized Identification

APPLICANT INFORMATION

Applicant name _____

Photo

Required Documents

Passport photograph, taken within one year, affixed to space provided.

Copy of name change or marriage certificate if name on any document is different from legal name.

Required identification - one primary and one secondary.

Identification presented to the Notary Public must be the **original** document issued by the government agency. Photocopies are acceptable only if certified by the issuing government agency to be true copies of the original.

PRIMARY		SECONDARY	
Document type	*Document number*	*Document type*	*Document number*
☐ Birth certificate		☐ Passport	
☐ Canadian citizen card		☐ Valid Canadian driver's license	
☐ Canadian identity card		☐ British Columbia identification card	
		☐ Naturalization certificate	
		☐ Canadian Forces identification	

_____ Date

_____ Applicant signature

NOTARY PUBLIC CERTIFICATION

I hereby verify that the person shown in the photograph affixed on this page is the same person:

- Whose name appears as the Applicant.
- Whose identity has been proven to my satisfaction through presentation of the identification indicated.
- Whose signature on this document was signed in my presence.

_____ Date

_____ Notary signature

Notary name _____

SEAL

Address _____

_____

Tel _____

APPLICATION FOR PRE-REGISTRATION

CANADA – NEW GRADUATE

Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)* :

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

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a. Criminal offence/Disciplinary action/Investigation
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d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

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_____ Applicant signature

APPLICATION FOR PRE-REGISTRATION
CANADA – NEW GRADUATE

Criminal Record Check Authorization

APPLICANT INFORMATION

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Mailing address _____
Street *City/town* *Province/State* *Postal Code*

_____ Contact phone _____
Country *Area code*

Gender ☐ Male ☐ Female B.C. Driver License _____

Birth date _____ Birthplace _____
YYYY-MM-DD *City/town* *Province/State* *Country*

Other names used or have used *(e.g. maiden name, birth name, previous married name)*

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_____ _____
Date Applicant signature

APPLICATION FOR PRE-REGISTRATION

USA

CHECKLIST

You must submit

1. ☐ Checklist *(page 1)*.
2. ☐ Application form *(page 2)*.
3. ☐ Copy of birth certificate or Canadian citizenship card.
4. ☐ Copy of university degree(s).
5. ☐ Letter of current standing to be mailed to College office directly from applicant's existing regulatory authorities. Letter must be dated within one month prior to the date of the application.
6. ☐ Notarized identification *(use form on page 3)*.
7. ☐ Certification of Pharmacy Related Employment *(use form on page 4)*.
8. ☐ Statutory declaration *(use form on page 5)*.
9. ☐ Criminal record check authorization *(use form on page 6)*.

You must submit IF

10. ☐ Copy of name change or marriage certificate - if name on any document is different from legal name.
11. ☐ Evidence of your authorization to work in Canada – if you are not a Canadian citizen or a permanent resident. Acceptable documents: Canadian citizenship card, Canadian passport, permanent resident card, social insurance card, or work permit.
12. ☐ A letter /certificate of standing from **each** regulatory body - if you have engaged in the practice of pharmacy or another health profession in a Canadian or foreign jurisdiction. Letter/certificate must be dated within three months prior to the date of the application and must be mailed to the college office directly from the regulatory bodies.

Photocopy both sides of documents where applicable.
Documents in a language other than English must be translated by a government official or an official translator.

APPLICATION FOR PRE-REGISTRATION

USA

Application Form

CONTACT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Address _____ Tel *(home)* _____

_____ Tel *(work)* _____

_____ Email _____
City *Province*

_____
Postal code *Country*

OTHER INFORMATION

1) Education *University/Country* _____

Degree/Year _____

2) Birth date *YYYY-MM -DD* _____ YES NO

3) Is this the first time you have applied for pre-registration with the College of Pharmacists of BC? ☐ ☐

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card #_____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Application fee *	335.00
GST	16.75
Total	**$351.75**

GST # R106953920

** Includes criminal record check*

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APPLICATION FOR PRE-REGISTRATION

USA

Notarized Identification

APPLICANT INFORMATION

Applicant name _____

Photo

Required Documents

Passport photograph, taken within one year, affixed to space provided.

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_____ Date

_____ Notary signature

Notary name _____

SEAL

Address _____

_____

Tel _____

APPLICATION FOR PRE-REGISTRATION

USA

Certification of Pharmacy Related Employment

EMPLOYMENT INFORMATION

Applicant name _____

Employer name _____

Address _____

_____

_____

Tel _____ Fax _____

Position _____ Total hours worked _____

Start date _____ End date _____

EMPLOYER CERTIFICATION

I certify that the above employment information is correct.

Name _____

Position _____

Pharmacy Manager / Pharmacy Owner / Human Resources Manager

_____ _____

Date Employer signature

APPLICATION FOR PRE-REGISTRATION

USA

Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)* :

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APPLICATION FOR PRE-REGISTRATION

USA

Criminal Record Check Authorization

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Birth date _____ Birthplace _____
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Surname First name Middle name
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Date Applicant signature

APPLICATION FOR PRE-REGISTRATION

USA - NEW GRADUATE

CHECKLIST

You must submit

1. ☐ Checklist *(page 1)*.
2. ☐ Application form *(page 2)*.
3. ☐ Copy of birth certificate or Canadian citizenship card.
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APPLICATION FOR PRE-REGISTRATION

USA - NEW GRADUATE

Application Form

CONTACT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Address _____ Tel *(home)* _____

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City *Province*

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Postal code *Country*

OTHER INFORMATION

1) Education *University/Country* _____

Degree/Year _____

2) Birth date *YYYY-MM -DD* _____ YES NO

3) Is this the first time you have applied for pre-registration with the College of Pharmacists of BC? ☐ ☐

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card #_____ Exp ____/____

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Cardholder signature _____

Application fee *	335.00
GST	16.75
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APPLICATION FOR PRE-REGISTRATION

USA - NEW GRADUATE

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Notary name _____

SEAL

Address _____

_____

Tel _____

APPLICATION FOR PRE-REGISTRATION

USA – NEW GRADUATE

Statutory Declaration (Form 5)

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Street *City/town* *Province/State* *Postal Code*

_____ Contact phone _____
Country *Area code*

Gender ☐ Male ☐ Female B.C. Driver License _____

Birth date _____ Birthplace _____
YYYY-MM-DD *City/town* *Province/State* *Country*

Other names used or have used *(e.g. maiden name, birth name, previous married name)*

1. _____
Surname *First name* *Middle name*
2. _____
Surname *First name* *Middle name*
3. _____
Surname *First name* *Middle name*

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA)

The information requested on this form is collected under the authority of the Criminal Records Review Act and in the case of child care facilities, the Community Care Facility Act, and the regulations which govern both these acts. The information provided will be used to fulfill the requirements of the Criminal Records Review Act for the release of criminal records information and is in compliance with the FOIPPA.

CONSENT FOR RELEASE OF INFORMATION AND ACKNOWLEDGEMENTS

Pursuant to the B.C. *Criminal Records Review Act*

- I hereby consent to a check for records of criminal convictions to determine whether I have a conviction or outstanding charge for any relevant offences under the Criminal Records Review Act.
- I hereby authorize the release to the Deputy Registrar any documents in the custody of the police, the court and crown counsel relating to an outstanding charge or conviction of any relevant offence as defined under the Criminal Records Review Act
- Where the results of this check indicate that a criminal record or outstanding charge for a relevant offence may exist, I agree to provide my fingerprints to verify any such criminal record.
- The Deputy Registrar will notify me and my organization that I have an outstanding charge or conviction for any relevant offence(s) and the matter has been referred to the Deputy Registrar.
- The Deputy Registrar will determine whether or not I present a risk to physical or sexual abuse to children.
- The Deputy Registrar's determination will be disclosed to my organization and it will include consideration of any relevant offence for which I have received a pardon.
- If I am charged with or convicted of a relevant offence at any time subsequent to the criminal record check authorized herein, I further agree to report the charge or conviction to my organization and provide my organization, in a timely manner, with a new-signed Consent to a Criminal Record Check form.

"Deputy Registrar" means a person appointed under the Public Service Act *as deputy registrar for the purposes of this Act.*

☐ I have read and understood the Consent for Release of Information and Acknowledgements above. I hereby consent to these terms as indicated by my signature below.

☐ I hereby authorize the College of Pharmacists of British Columbia to conduct criminal record checks on an ongoing basis every five years. I understand that I may withdraw this consent for future criminal record checks.

_____ _____
Date Applicant signature

APPLICATION FOR PRE-REGISTRATION

INTERNATIONAL PHARMACY GRADUATE (IPG)

CHECKLIST

You must submit

1. ☐ Checklist *(page 1)*.
2. ☐ Application form *(page 2)*.
3. ☐ Copy of birth certificate or Canadian citizenship card.
4. ☐ Copy of university degree(s).
5. ☐ Copy of PEBC letter confirming completion of PEBC Evaluating Exam.
6. ☐ Letter of current standing to be mailed to College office directly from applicant's existing regulatory authorities. Letter must be dated within three months prior to the date of the application.
7. ☐ Notarized identification *(use form on page 3)*.
8. ☐ Statutory declaration *(use form on page 4)*.
9. ☐ Criminal record check authorization *(use form on page 5)*.

You must submit IF

10. ☐ Copy of name change or marriage certificate - if name on any document is different from legal name.
11. ☐ Evidence of your authorization to work in Canada – if you are not a Canadian citizen or a permanent resident. Acceptable documents: Canadian citizenship card, Canadian passport, permanent resident card, social insurance card, or work permit.
12. ☐ A letter/certificate of standing from **each** regulatory body - if you have engaged in the practice of pharmacy or another health profession in another jurisdiction. Letter/certificate must be dated within three months prior to the date of the application and must be mailed to the college office directly from the regulatory bodies.

Photocopy both sides of documents where applicable.
Documents in a language other than English must be translated by a government official or an official translator.

APPLICATION FOR PRE-REGISTRATION
INTERNATIONAL PHARMACY GRADUATE (IPG)

Application Form

CONTACT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Address _____ Tel *(home)* _____

_____ Tel *(work)* _____

_____ Email _____
City *Province*

_____ _____
Postal code *Country*

OTHER INFORMATION

1) Education *University/Country* _____

Degree/Year _____

2) Birth date *YYYY-MM -DD* _____ YES NO

3) Is this the first time you have applied for pre-registration with the College of Pharmacists of BC? ☐ ☐

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card #_____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Application fee *	335.00
GST	16.75
Total	**$351.75**

GST # R106953920

* *Includes criminal record check*

_____ _____
Date Applicant signature

APPLICATION FOR PRE-REGISTRATION

INTERNATIONAL PHARMACY GRADUATE (IPG)

Notarized Identification

APPLICANT INFORMATION

Applicant name _____

Photo

Required Documents

Passport photograph, taken within one year, affixed to space provided.

Copy of name change or marriage certificate if name on any document is different from legal name.

Required identification - one primary and one secondary.

Identification presented to the Notary Public must be the **original** document issued by the government agency. Photocopies are acceptable only if certified by the issuing government agency to be true copies of the original.

PRIMARY		SECONDARY	
Document type	*Document number*	*Document type*	*Document number*
☐ Birth certificate		☐ Passport	
☐ Canadian citizen card		☐ Valid Canadian driver's license	
☐ Canadian identity card		☐ British Columbia identification card	
		☐ Naturalization certificate	
		☐ Canadian Forces identification	

_____ Date

_____ Applicant signature

NOTARY PUBLIC CERTIFICATION

I hereby verify that the person shown in the photograph affixed on this page is the same person:

- Whose name appears as the Applicant.
- Whose identity has been proven to my satisfaction through presentation of the identification indicated.
- Whose signature on this document was signed in my presence.

_____ Date

_____ Notary signature

Notary name _____

SEAL

Address _____

_____

Tel _____

APPLICATION FOR PRE-REGISTRATION

INTERNATIONAL PHARMACY GRADUATE (IPG)

Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)* :

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC.

- *a charge relating to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs, or relating to any criminal offense;*
- *a finding of guilt in relation to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above is not true (i.e. if any of the above boxes is not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

_____ Date

_____ Applicant signature

APPLICATION FOR PRE-REGISTRATION
INTERNATIONAL PHARMACY GRADUATE (IPG)

Criminal Record Check Authorization

APPLICANT INFORMATION

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Mailing address _____
Street *City/town* *Province/State* *Postal Code*

_____ Contact phone _____
Country *Area code*

Gender ☐ Male ☐ Female B.C. Driver License _____

Birth date _____ Birthplace _____
YYYY-MM-DD *City/town* *Province/State* *Country*

Other names used or have used *(e.g. maiden name, birth name, previous married name)*

1. _____
Surname *First name* *Middle name*
2. _____
Surname *First name* *Middle name*
3. _____
Surname *First name* *Middle name*

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA)

The information requested on this form is collected under the authority of the Criminal Records Review Act and in the case of child care facilities, the Community Care Facility Act, and the regulations which govern both these acts. The information provided will be used to fulfill the requirements of the Criminal Records Review Act for the release of criminal records information and is in compliance with the FOIPPA.

CONSENT FOR RELEASE OF INFORMATION AND ACKNOWLEDGEMENTS

Pursuant to the B.C. *Criminal Records Review Act*

- I hereby consent to a check for records of criminal convictions to determine whether I have a conviction or outstanding charge for any relevant offences under the Criminal Records Review Act.
- I hereby authorize the release to the Deputy Registrar any documents in the custody of the police, the court and crown counsel relating to an outstanding charge or conviction of any relevant offence as defined under the Criminal Records Review Act
- Where the results of this check indicate that a criminal record or outstanding charge for a relevant offence may exist, I agree to provide my fingerprints to verify any such criminal record.
- The Deputy Registrar will notify me and my organization that I have an outstanding charge or conviction for any relevant offence(s) and the matter has been referred to the Deputy Registrar.
- The Deputy Registrar will determine whether or not I present a risk to physical or sexual abuse to children.
- The Deputy Registrar's determination will be disclosed to my organization and it will include consideration of any relevant offence for which I have received a pardon.
- If I am charged with or convicted of a relevant offence at any time subsequent to the criminal record check authorized herein, I further agree to report the charge or conviction to my organization and provide my organization, in a timely manner, with a new-signed Consent to a Criminal Record Check form.

"Deputy Registrar" means a person appointed under the Public Service Act *as deputy registrar for the purposes of this Act.*

☐ I have read and understood the Consent for Release of Information and Acknowledgements above. I hereby consent to these terms as indicated by my signature below.

☐ I hereby authorize the College of Pharmacists of British Columbia to conduct criminal record checks on an ongoing basis every five years. I understand that I may withdraw this consent for future criminal record checks.

_____ _____
Date Applicant signature

APPLICATION FOR
TEMPORARY PHARMACIST REGISTRATION

APPLICANT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Name _____
Last name (Surname) *First name* *Other name(s)*

Address _____ Tel *(home)* _____

_____ Tel *(work)* _____

_____ Email _____
City *Province*

_____
Postal code *Country*

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Registration fee	157.50
GST	7.88
Total	**$165.38**

GST # R106953920

I attest that I am in compliance with the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

I have professional liability insurance that meets the following criteria:

- ☐ Provides a minimum of $2 million coverage.
- ☐ Provides occurrence based coverage or claims made with extended reporting period of at least 3 years.
- ☐ If not in the pharmacists' name, the group policy covers the pharmacist as an individual.

I have signed and attached:

- ☐ Statutory Declaration *(use form on page 2).*
- ☐ Pharmacists Confidentiality Undertaking *(use form on page 3).*

_____ _____
Date Applicant signature

APPLICATION FOR

TEMPORARY PHARMACIST REGISTRATION

Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)* :

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC.

- *a charge relating to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs,or relating to any criminal offense;*
- *a finding of guilt in relation to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above is not true (i.e. if any of the above boxes is not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

_____ _____

Date Applicant signature

APPLICATION FOR

TEMPORARY PHARMACIST REGISTRATION

Pharmacist Confidentiality Undertaking

I agree to access the **PharmaNet** clinical and patient database through the in-pharmacy computer system, on the following terms and conditions:

- ☐ I will not access or use any clinical or patient information in the PharmaNet database or the in-Pharmacy computer system for any purpose other than those authorized by the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act and the Bylaws of the College of Pharmacists of BC made pursuant to these Acts.

- ☐ I agree at all times to treat as confidential all information referred to in paragraph (1) and will not participate in or permit, the unauthorized release, publication or disclosure of the said information to any person, corporation or other entity under any circumstances except as authorized by the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act and the Bylaws of the College of Pharmacists of BC made pursuant to these Acts.

- ☐ I agree at all times, to treat as confidential all information relating to the security and management of the PharmaNet database and the in-pharmacy computer system.

- ☐ I agree to be bound by the provisions of this agreement and will continue to do so following termination of employment in the pharmacy for any reason.

- ☐ I agree to adhere to all policies and procedures issued by the pharmacy manager and/or the pharmacy owner, consistent with legislation, policies, procedures and standards issued by the College of Pharmacists of British Columbia or the Province of British Columbia, related to the confidentiality, privacy and security of the patient or clinical information contained in the PharmaNet database and the in-pharmacy computer database.

_____ Date

_____ Applicant signature

Note:

1. *Attach original with application for registration.*
2. *Make a copy for the pharmacy manager - to be retained in the pharmacy files.*

APPLICATION FOR

STUDENT PHARMACIST (UBC) REGISTRATION

Please submit this application to the College of Pharmacists of BC

CHECKLIST

You must submit

1. ☐ Checklist *(page 1)*.
2. ☐ Application form *(page 2)*.
3. ☐ Copy of birth certificate or Canadian citizenship card *(both sides)*.
4. ☐ Copy of letter from UBC confirming registration with Faculty of Pharmacy.
5. ☐ Notarized identification *(use form on page 3)*.
6. ☐ Statutory declaration *(use form on page 4)*.
7. ☐ Criminal record check authorization *(use form on page 5)*.

You must submit IF

8. ☐ Copy of name change or marriage certificate - if name on any document is different from legal name.
9. ☐ Evidence of your authorization to work in Canada – if you are not a Canadian citizen or a permanent resident. Acceptable documents: Canadian citizenship card, Canadian passport, permanent resident card, social insurance card, or work permit.
10. ☐ A letter/certificate of standing from **each** regulatory body - if you have engaged in the practice of pharmacy or another health profession in another jurisdiction. Letter/ certificate must be dated within three months prior to the date of the application and must be mailed to the college office directly from the regulatory bodies.

Photocopy both sides of documents where applicable.
Documents in a language other than English must be translated by a government official or an official translator.

APPLICATION FOR

STUDENT PHARMACIST (UBC) REGISTRATION

Application Form

CONTACT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Address _____ Tel *(home)* _____

_____ Tel *(work)* _____

_____ Email _____
City *Province*

_____
Postal code *Country*

OTHER INFORMATION

1) Education *UBC Student ID #* _____

2) Birth date *YYYY-MM -DD* _____

	YES	NO
3) Is this the first time you have applied for pre-registration with the College of Pharmacists of BC?	☐	☐

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card #_____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Application fee *	177.50
GST	8.88
Total	**$186.38**

GST # R106953920

** Includes criminal record check*

I hereby authorize the College of Pharmacists of British Columbia to disclose my criminal record check information to the University of British Columbia for the purposes of compliance with the Criminal Records Review Act.

_____ Date

_____ Applicant signature

APPLICATION FOR

STUDENT PHARMACIST (UBC) REGISTRATION

Notarized Identification

APPLICANT INFORMATION

Applicant name _____

Photo

Required Documents

Passport photograph, taken within one year, affixed to space provided.

Copy of name change or marriage certificate if name on any document is different from legal name.

Required identification - one primary and one secondary.

Identification presented to the Notary Public must be the **original** document issued by the government agency. Photocopies are acceptable only if certified by the issuing government agency to be true copies of the original.

PRIMARY		SECONDARY	
Document type	*Document number*	*Document type*	*Document number*
☐ Birth certificate		☐ Passport	
☐ Canadian citizen card		☐ Valid Canadian driver's license	
☐ Canadian identity card		☐ British Columbia identification card	
		☐ Naturalization certificate	
		☐ Canadian Forces identification	

_____ Date

_____ Applicant signature

NOTARY PUBLIC CERTIFICATION

I hereby verify that the person shown in the photograph affixed on this page is the same person:

- Whose name appears as the Applicant.
- Whose identity has been proven to my satisfaction through presentation of the identification indicated.
- Whose signature on this document was signed in my presence.

_____ Date

_____ Notary signature

Notary name _____

SEAL

Address _____

_____

Tel _____

APPLICATION FOR

STUDENT PHARMACIST (UBC) REGISTRATION

Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)* :

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC.

- *a charge relating to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs, or relating to any criminal offense;*
- *a finding of guilt in relation to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above is not true (i.e. if any of the above boxes is not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

_____ Date

_____ Applicant signature

APPLICATION FOR

STUDENT PHARMACIST (UBC) REGISTRATION

Criminal Record Check Authorization

APPLICANT INFORMATION

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Mailing address _____
Street *City/town* *Province/State* *Postal Code*

_____ Contact phone _____
Country *Area code*

Gender ☐ Male ☐ Female B.C. Driver License _____

Birth date _____ Birthplace _____
YYYY-MM-DD *City/town* *Province/State* *Country*

Other names used or have used *(e.g. maiden name, birth name, previous married name)*

1. _____
Surname *First name* *Middle name*
2. _____
Surname *First name* *Middle name*
3. _____
Surname *First name* *Middle name*

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA)

The information requested on this form is collected under the authority of the Criminal Records Review Act and in the case of child care facilities, the Community Care Facility Act, and the regulations which govern both these acts. The information provided will be used to fulfill the requirements of the Criminal Records Review Act for the release of criminal records information and is in compliance with the FOIPPA.

CONSENT FOR RELEASE OF INFORMATION AND ACKNOWLEDGEMENTS

Pursuant to the B.C. *Criminal Records Review Act*

- I hereby consent to a check for records of criminal convictions to determine whether I have a conviction or outstanding charge for any relevant offences under the Criminal Records Review Act.
- I hereby authorize the release to the Deputy Registrar any documents in the custody of the police, the court and crown counsel relating to an outstanding charge or conviction of any relevant offence as defined under the Criminal Records Review Act
- Where the results of this check indicate that a criminal record or outstanding charge for a relevant offence may exist, I agree to provide my fingerprints to verify any such criminal record.
- The Deputy Registrar will notify me and my organization that I have an outstanding charge or conviction for any relevant offence(s) and the matter has been referred to the Deputy Registrar.
- The Deputy Registrar will determine whether or not I present a risk to physical or sexual abuse to children.
- The Deputy Registrar's determination will be disclosed to my organization and it will include consideration of any relevant offence for which I have received a pardon.
- If I am charged with or convicted of a relevant offence at any time subsequent to the criminal record check authorized herein, I further agree to report the charge or conviction to my organization and provide my organization, in a timely manner, with a new-signed Consent to a Criminal Record Check form.

"Deputy Registrar" means a person appointed under the Public Service Act *as deputy registrar for the purposes of this Act.*

☐ I have read and understood the Consent for Release of Information and Acknowledgements above. I hereby consent to these terms as indicated by my signature below.

☐ I hereby authorize the College of Pharmacists of British Columbia to conduct criminal record checks on an ongoing basis every five years. I understand that I may withdraw this consent for future criminal record checks.

_____ _____
Date Applicant signature

APPLICATION FOR PRE-REGISTRATION

STUDENT PHARMACIST (NON UBC) REGISTRATION

Please submit this application to the College of Pharmacists of BC

CHECKLIST

You must submit

1. ☐ Checklist *(page 1)*.
2. ☐ Application form *(page 2)*.
3. ☐ Copy of birth certificate or Canadian citizenship card *(both sides)*.
4. ☐ Copy of student ID card *(both sides)*.
5. ☐ Notarized identification *(use form on page 3)*.
6. ☐ Statutory declaration *(use form on page 4)*.
7. ☐ Criminal record check authorization *(use form on page 5)*.

You must submit IF

8. ☐ Copy of name change or marriage certificate - if name on any document is different from legal name.
9. ☐ Evidence of your authorization to work in Canada – if you are not a Canadian citizen or a permanent resident. Acceptable documents: Canadian citizenship card, Canadian passport, permanent resident card, social insurance card, or work permit.
10. ☐ A letter/certificate of standing from **each** regulatory body - if you have engaged in the practice of pharmacy or another health profession in another jurisdiction. Letter/certificate must be dated within three months prior to the date of the application and must be mailed to the college office directly from the regulatory bodies.

Photocopy both sides of documents where applicable.
Documents in a language other than English must be translated by a government official or an official translator.

APPLICATION FOR PRE-REGISTRATION
STUDENT PHARMACIST (NON UBC) REGISTRATION

Application Form

CONTACT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Address _____ Tel *(home)* _____

_____ Tel *(work)* _____

_____ Email _____
City *Province*

_____ _____
Postal code *Country*

OTHER INFORMATION

1) Education *Student ID #* _____

Canadian University _____

2) Birth date *YYYY-MM -DD* _____

	YES	NO
3) Is this the first time you have applied for pre-registration with the College of Pharmacists of BC?	☐	☐

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card #_____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Application fee *	177.50
GST	8.88
Total	**$186.38**

GST # R106953920

* *Includes criminal record check*

_____ _____
Date Applicant signature

APPLICATION FOR PRE-REGISTRATION

STUDENT PHARMACIST (NON UBC) REGISTRATION

Notarized Identification

APPLICANT INFORMATION

Applicant name _____

Photo

Required Documents

Passport photograph, taken within one year, affixed to space provided.

Copy of name change or marriage certificate if name on any document is different from legal name.

Required identification - one primary and one secondary.

Identification presented to the Notary Public must be the **original** document issued by the government agency. Photocopies are acceptable only if certified by the issuing government agency to be true copies of the original.

PRIMARY		SECONDARY	
Document type	*Document number*	*Document type*	*Document number*
☐ Birth certificate		☐ Passport	
☐ Canadian citizen card		☐ Valid Canadian driver's license	
☐ Canadian identity card		☐ British Columbia identification card	
		☐ Naturalization certificate	
		☐ Canadian Forces identification	

_____ Date

_____ Applicant signature

NOTARY PUBLIC CERTIFICATION

I hereby verify that the person shown in the photograph affixed on this page is the same person:

- Whose name appears as the Applicant.
- Whose identity has been proven to my satisfaction through presentation of the identification indicated.
- Whose signature on this document was signed in my presence.

_____ Date

_____ Notary signature

Notary name _____

SEAL

Address _____

_____

Tel _____

APPLICATION FOR PRE-REGISTRATION

STUDENT PHARMACIST (NON UBC) REGISTRATION

Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)* :

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC.

- *a charge relating to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs, or relating to any criminal offense;*
- *a finding of guilt in relation to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above is not true (i.e. if any of the above boxes is not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

_____ Date

_____ Applicant signature

APPLICATION FOR PRE-REGISTRATION
STUDENT PHARMACIST (NON UBC) REGISTRATION

Criminal Record Check Authorization

APPLICANT INFORMATION

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Mailing address _____
Street *City/town* *Province/State* *Postal Code*

_____ Contact phone _____
Country *Area code*

Gender ☐ Male ☐ Female B.C. Driver License _____

Birth date _____ Birthplace _____
YYYY-MM-DD *City/town* *Province/State* *Country*

Other names used or have used *(e.g. maiden name, birth name, previous married name)*

1. _____
Surname *First name* *Middle name*
2. _____
Surname *First name* *Middle name*
3. _____
Surname *First name* *Middle name*

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA)

The information requested on this form is collected under the authority of the Criminal Records Review Act and in the case of child care facilities, the Community Care Facility Act, and the regulations which govern both these acts. The information provided will be used to fulfill the requirements of the Criminal Records Review Act for the release of criminal records information and is in compliance with the FOIPPA.

CONSENT FOR RELEASE OF INFORMATION AND ACKNOWLEDGEMENTS

Pursuant to the B.C. *Criminal Records Review Act*

- I hereby consent to a check for records of criminal convictions to determine whether I have a conviction or outstanding charge for any relevant offences under the Criminal Records Review Act.
- I hereby authorize the release to the Deputy Registrar any documents in the custody of the police, the court and crown counsel relating to an outstanding charge or conviction of any relevant offence as defined under the Criminal Records Review Act
- Where the results of this check indicate that a criminal record or outstanding charge for a relevant offence may exist, I agree to provide my fingerprints to verify any such criminal record.
- The Deputy Registrar will notify me and my organization that I have an outstanding charge or conviction for any relevant offence(s) and the matter has been referred to the Deputy Registrar.
- The Deputy Registrar will determine whether or not I present a risk to physical or sexual abuse to children.
- The Deputy Registrar's determination will be disclosed to my organization and it will include consideration of any relevant offence for which I have received a pardon.
- If I am charged with or convicted of a relevant offence at any time subsequent to the criminal record check authorized herein, I further agree to report the charge or conviction to my organization and provide my organization, in a timely manner, with a new-signed Consent to a Criminal Record Check form.

"Deputy Registrar" means a person appointed under the Public Service Act *as deputy registrar for the purposes of this Act.*

☐ I have read and understood the Consent for Release of Information and Acknowledgements above. I hereby consent to these terms as indicated by my signature below.

☐ I hereby authorize the College of Pharmacists of British Columbia to conduct criminal record checks on an ongoing basis every five years. I understand that I may withdraw this consent for future criminal record checks.

_____ _____
Date Applicant signature

APPLICATION FOR
PHARMACY TECHNICIAN REGISTRATION

APPLICANT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Name _____
Last name (Surname) *First name* *Other name(s)*

Address _____ Tel *(home)* _____

_____ Tel *(work)* _____

_____ Email _____
City *Province*

_____
Postal code *Country*

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Registration fee	420.00
GST	21.00
Total	**$441.00**

GST # R106953920

I attest that I am in compliance with the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

I have professional liability insurance that meets the following criteria *(please check the box(es) below)*:

- ☐ Provides a minimum of $2 million coverage.
- ☐ Provides occurrence based coverage or claims made with extended reporting period of at least 3 years.
- ☐ If not in the pharmacists' name, the group policy covers the pharmacist as an individual.

I have signed and attached *(please check the box(es) below)*:

- ☐ Statutory Declaration *(use form on page 2).*
- ☐ Pharmacy Technician Confidentiality Undertaking *(use form on page 3).*

_____ _____
Date Applicant signature

APPLICATION FOR

PHARMACY TECHNICIAN REGISTRATION

Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)* :

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC.

- *a charge relating to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs, or relating to any criminal offense;*
- *a finding of guilt in relation to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above is not true (i.e. if any of the above boxes is not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

_____ Date

_____ Applicant signature

APPLICATION FOR

PHARMACY TECHNICIAN REGISTRATION

Pharmacy Technician Confidentiality Undertaking

I agree to access the **PharmaNet** clinical and patient database through the in-pharmacy computer system, on the following terms and conditions:

- ☐ I will not access or use any clinical or patient information in the PharmaNet database or the in-Pharmacy computer system for any purpose other than those authorized by the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act and the Bylaws of the College of Pharmacists of BC made pursuant to these Acts.

- ☐ I agree at all times to treat as confidential all information referred to in paragraph (1) and will not participate in or permit, the unauthorized release, publication or disclosure of the said information to any person, corporation or other entity under any circumstances except as authorized by the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act and the Bylaws of the College of Pharmacists of BC made pursuant to these Acts.

- ☐ I agree at all times, to treat as confidential all information relating to the security and management of the PharmaNet database and the in-pharmacy computer system.

- ☐ I agree to be bound by the provisions of this agreement and will continue to do so following termination of employment in the pharmacy for any reason.

- ☐ I agree to adhere to all policies and procedures issued by the pharmacy manager and/or the pharmacy owner, consistent with legislation, policies, procedures and standards issued by the College of Pharmacists of British Columbia or the Province of British Columbia, related to the confidentiality, privacy and security of the patient or clinical information contained in the PharmaNet database and the in-pharmacy computer database.

_____ Date

_____ Applicant signature

Note:

1. *Attach original with application for registration.*
2. *Make a copy for the pharmacy manager - to be retained in the pharmacy files.*

APPLICATION FOR PRE-REGISTRATION

CURRENT PHARMACY TECHNICIAN (PRE-2015)

Please submit this application to the College of Pharmacists of BC

CHECKLIST

You must submit

1. ☐ Checklist *(page 1)*.
2. ☐ Application form *(page 2)*.
3. ☐ Copy of birth certificate or Canadian citizenship card *(both sides)*.
4. ☐ Evidence of English Language Proficiency (ELP).
   (Copy of transcript or diploma that confirms graduation from a secondary school, university, community college, private vocational program or equivalent in Canada or the continental U.S. or a NAPRA recognized ELP assessment for pharmacy technicians.)
5. ☐ Notarized identification *(use form on page 3)*.
6. ☐ Employment certification *(use form on page 6)*.
   (Not required if PEBC letter confirming completion of PEBC Evaluating Exam is provided.)
7. ☐ Statutory declaration *(use form on page 4)*.
8. ☐ Criminal record check authorization *(use form on page 5)*.

You must submit IF APPLICABLE

9. ☐ Copy of name change or marriage certificate - if name on any document is different from legal name.
10. ☐ Evidence of your authorization to work in Canada – if you are not a Canadian citizen or a permanent resident. Acceptable documents: Canadian citizenship card, Canadian passport, permanent resident card, social insurance card, or work permit.
11. ☐ A letter/certificate of standing from **each** regulatory body - if you have engaged in the practice of pharmacy or another health profession in another jurisdiction. Letter/certificate must be dated within three months prior to the date of the application and must be mailed to the college office directly from the regulatory bodies.
12. ☐ Copy of PEBC letter confirming completion of PEBC Evaluating Exam.
13. ☐ Copy of pharmacy technician certificate from PTCB-AB or OCP (up to 2008).
14. ☐ Copy of university degree from an accredited pharmacist degree program in Canada or in the continental United States.

Photocopy both sides of documents where applicable.
Documents in a language other than English must be translated by a government official or an official translator.

APPLICATION FOR PRE-REGISTRATION
CURRENT PHARMACY TECHNICIAN (PRE-2015)

Application Form

CONTACT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Home Address _____ Tel *(home)* _____

_____ Email _____

_____
City *Province*

_____
Postal code *Country*

Work Address _____ PharmaCare Code _____
Pharmacy Name

_____ Tel *(work)* _____
Street Address *City*

OTHER INFORMATION

1) Education *Program/Country* _____

Certification/Year _____

2) Birth date *YYYY-MM -DD* _____

	YES	NO
3) Is this the first time you have applied for pre-registration with the College of Pharmacists of BC?	☐	☐

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card #_____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Application fee *	230.00
GST	11.50
Total	**$241.50**

GST # R106953920

** Includes criminal record check*

_____ _____
Date Applicant signature

APPLICATION FOR PRE-REGISTRATION

CURRENT PHARMACY TECHNICIAN (PRE-2015)

Notarized Identification

APPLICANT INFORMATION

Applicant name _____

Photo

Required Documents

Passport photograph, taken within one year, affixed to space provided.

Copy of name change or marriage certificate if name on any document is different from legal name.

Required identification - one primary and one secondary.

Identification presented to the Notary Public must be the **original** document issued by the government agency. Photocopies are acceptable only if certified by the issuing government agency to be true copies of the original.

PRIMARY		SECONDARY	
Document type	*Document number*	*Document type*	*Document number*
☐ Birth certificate		☐ Passport	
☐ Canadian citizen card		☐ Valid Canadian driver's license	
☐ Canadian identity card		☐ British Columbia identification card	
		☐ Naturalization certificate	
		☐ Canadian Forces identification	

_____ Date

_____ Applicant signature

NOTARY PUBLIC CERTIFICATION

I hereby verify that the person shown in the photograph affixed on this page is the same person:

- Whose name appears as the Applicant.
- Whose identity has been proven to my satisfaction through presentation of the identification indicated.
- Whose signature on this document was signed in my presence.

_____ Date

_____ Notary signature

Notary name _____

SEAL

Address _____

_____

Tel _____

APPLICATION FOR PRE-REGISTRATION

CURRENT PHARMACY TECHNICIAN (PRE-2015)

Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)* :

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

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☐ 5. I am a person of good character.

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- *a finding of guilt in relation to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs or in relation to any criminal offense;*
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On a separate sheet of paper, provide details if any of the above is not true (i.e. if any of the above boxes is not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

_____ Date

_____ Applicant signature

APPLICATION FOR PRE-REGISTRATION

CURRENT PHARMACY TECHNICIAN (PRE-2015)

Criminal Record Check Authorization

APPLICANT INFORMATION

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Mailing address _____
Street *City/town* *Province/State* *Postal Code*

_____ Contact phone _____
Country *Area code*

Gender ☐ Male ☐ Female B.C. Driver License _____

Birth date _____ Birthplace _____
(YYY-MM-DD *City/town* *Province/State* *Country*

Other names used or have used *(e.g. maiden name, birth name, previous married name)*

1. _____
Surname *First name* *Middle name*
2. _____
Surname *First name* *Middle name*
3. _____ _____
Surname *First name* *Middle name*

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA)

The information requested on this form is collected under the authority of the Criminal Records Review Act and in the case of child care facilities, the Community Care Facility Act, and the regulations which govern both these acts. The information provided will be used to fulfill the requirements of the Criminal Records Review Act for the release of criminal records information and is in compliance with the FOIPPA.

CONSENT FOR RELEASE OF INFORMATION AND ACKNOWLEDGEMENTS

Pursuant to the B.C. *Criminal Records Review Act*

- I hereby consent to a check for records of criminal convictions to determine whether I have a conviction or outstanding charge for any relevant offences under the Criminal Records Review Act.
- I hereby authorize the release to the Deputy Registrar any documents in the custody of the police, the court and crown counsel relating to an outstanding charge or conviction of any relevant offence as defined under the Criminal Records Review Act
- Where the results of this check indicate that a criminal record or outstanding charge for a relevant offence may exist, I agree to provide my fingerprints to verify any such criminal record.
- The Deputy Registrar will notify me and my organization that I have an outstanding charge or conviction for any relevant offence(s) and the matter has been referred to the Deputy Registrar.
- The Deputy Registrar will determine whether or not I present a risk to physical or sexual abuse to children.
- The Deputy Registrar's determination will be disclosed to my organization and it will include consideration of any relevant offence for which I have received a pardon.
- If I am charged with or convicted of a relevant offence at any time subsequent to the criminal record check authorized herein, I further agree to report the charge or conviction to my organization and provide my organization, in a timely manner, with a new-signed Consent to a Criminal Record Check form.

"Deputy Registrar" means a person appointed under the Public Service Act *as deputy registrar for the purposes of this Act.*

☐ I have read and understood the Consent for Release of Information and Acknowledgements above. I hereby consent to these terms as indicated by my signature below.

☐ I hereby authorize the College of Pharmacists of British Columbia to conduct criminal record checks on an ongoing basis every five years. I understand that I may withdraw this consent for future criminal record checks.

_____ _____
Date Applicant signature

APPLICATION FOR PRE-REGISTRATION

CURRENT PHARMACY TECHNICIAN (PRE-2015)

Employment Certification

STATEMENT OF COMPLETION OF REQUIRED HOURS OF WORK

This is to certify that I, ____,
PRINT applicant name

have completed 2,000 hours of work in the past 36 months in Canada, as cited below, in the field of pharmacy and in compliance with the requirements of The Pharmacy Examining Board of Canada (refer to Appendix) " Criteria for Field of Pharmacy".

______________________________ ______________________________
Applicant Signature Date

Pharmacy Name, Address and Telephone Number	Job Title of Applicant	Date Started & Hours Worked in 36 Months	*Supervising Pharmacist Name (please print) & Registration #	*Signature of Supervising Pharmacist and Date
Name:____________ Address:____________ ____________ Tel: ____________	☐ Pharmacy Assistant/ Technician ☐ Volunteer ☐ Other (please specify): ____________	Date Started: ____________ (month/year) Hours/36months: ____________	Name:____________ Reg #: ____________	Signature: ____________ Date: ____________
Name:____________ Address:____________ ____________ Tel: ____________	☐ Pharmacy Assistant/ Technician ☐ Volunteer ☐ Other (please specify): ____________	Date Started: ____________ (month/year) Hours/36months: ____________	Name:____________ Reg #: ____________	Signature: ____________ Date: ____________
Name:____________ Address:____________ ____________ Tel: ____________	☐ Pharmacy Assistant/ Technician ☐ Volunteer ☐ Other (please specify): ____________	Date Started: ____________ (month/year) Hours/36months: ____________	Name:____________ Reg #: ____________	Signature: ____________ Date: ____________
Name:____________ Address:____________ ____________ Tel: ____________	☐ Pharmacy Assistant/ Technician ☐ Volunteer ☐ Other (please specify): ____________	Date Started: ____________ (month/year) Hours/36months: ____________	Name:____________ Reg #: ____________	Signature: ____________ Date: ____________
Name:____________ Address:____________ ____________ Tel: ____________	☐ Pharmacy Assistant/ Technician ☐ Volunteer ☐ Other (please specify): ____________	Date Started: ____________ (month/year) Hours/36months: ____________	Name:____________ Reg #: ____________	Signature: ____________ Date: ____________

***Statement of Declaration and Verification** (to be signed for in the above table by pharmacist(s) supervising this applicant for the work hours cited):

I hereby certify that while working under my supervision, the applicant was working in a setting consistent with some or all of the activities outlined in the Appendix "Criteria for Field of Pharmacy". I also hereby certify that the information completed above is true and that I have been in direct supervision of this applicant. As such, I have printed and signed my name as a Statement of Declaration and Verification in the above table adjacent to the applicant's specified hours for those specified hours while he/she was under my supervision.

APPLICATION FOR PRE-REGISTRATION

CURRENT PHARMACY TECHNICIAN (PRE-2015)

Employment Certification

APPENDIX: CRITERIA FOR FIELD OF PHARMACY

The field of pharmacy includes practice where some of the following tasks are performed:

PRESCRIPTION AND PATIENT INFORMATION PROCESSING

- Creating and maintaining patient records
- Receiving and transferring prescriptions or requests for prescription refills, including assessing prescriptions for clarity, completeness, authenticity and legal requirements
- Preparing products for release and/or distribution, including:
  - Product selection
  - Retrieving, counting, pouring, weighing, measuring, compounding and reconstituting sterile and non-sterile products
  - Packaging products to maintain integrity, including selecting type of prescription container, pre-packaging medications and affixing prescription and auxiliary labels
- Releasing and distributing products in a manner that ensures patient safety

COMMUNICATION AND EDUCATION

- Communicating with patients, patients' agents, pharmacists, other pharmacy technicians and other members of the health care team, and educating, where appropriate, in order to promote and support optimal patient care and well-being

MANAGEMENT

- Managing operations, administrative activities, and financial elements associated with the processing of prescriptions

OTHER RELATED PHARMACY SERVICES

- Generating patient care data (i.e. medication administration record, medication review)
- Managing systems for drug distribution and inventory control to ensure patient safety and the safety, accuracy, quality, integrity and timeliness of the products, including:
  - Determining and maintaining inventory requirements
  - Auditing inventory and documenting discrepancies for narcotic, controlled, and targeted-controlled substances
- Maintaining drug information files
- Maintaining packaging and dispensing equipment and storage facilities
- Replenishing medications for nursing units, night cupboards, emergency boxes and cardiac arrest kits

PROFESSIONAL COLLABORATION AND TEAMWORK

- Working in collaborative relationships within health care teams to optimize patient safety and improve health outcomes

QUALITY ASSURANCE

- Collaborating in developing, implementing and evaluating quality assurance and risk management policies, procedures, and activities related to the safe use of medications and the safety and integrity of pharmaceutical products

Note:
These criteria are adapted from NAPRA's "Professional Competencies for Canadian Pharmacy Technicians at Entry to Practice".

APPLICATION FOR PRE-REGISTRATION

CANADA - NEW PHARMACY TECHNICIAN GRADUATE

Please submit this application to the College of Pharmacists of BC

CHECKLIST

You must submit

1. ☐ Checklist *(page 1)*.
2. ☐ Application form *(page 2)*.
3. ☐ Copy of birth certificate or Canadian citizenship card *(both sides)*.
4. ☐ Copy of CCAPP accredited pharmacy technician program certificate(s).
5. ☐ Notarized identification *(use form on page 3)*.
6. ☐ Statutory declaration *(use form on page 4)*.
7. ☐ Criminal record check authorization *(use form on page 5)*.

You must submit IF APPLICABLE

8. ☐ Copy of name change or marriage certificate - if name on any document is different from legal name.
9. ☐ Evidence of your authorization to work in Canada – if you are not a Canadian citizen or a permanent resident. Acceptable documents: Canadian citizenship card, Canadian passport, permanent resident card, social insurance card, or work permit.
10. ☐ A letter/certificate of standing from **each** regulatory body - if you have engaged in the practice of pharmacy or another health profession in another jurisdiction. Letter/certificate must be dated within three months prior to the date of the application and must be mailed to the college office directly from the regulatory bodies.

Photocopy both sides of documents where applicable.
Documents in a language other than English must be translated by a government official or an official translator.

APPLICATION FOR PRE-REGISTRATION
CANADA - NEW PHARMACY TECHNICIAN GRADUATE

Application Form

CONTACT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Home Address _____ Tel *(home)* _____

_____ Email _____

_____
City *Province*

_____
Postal code *Country*

Work Address _____ PharmaCare Code _____
Pharmacy Name

_____ Tel *(work)* _____
Street Address *City*

OTHER INFORMATION

1) Education *Program/Country* _____

Certification/Year _____

2) Birth date *YYYY-MM -DD* _____

	YES	NO
3) Is this the first time you have applied for pre-registration with the College of Pharmacists of BC?	☐	☐

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card #_____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Application fee *	230.00
GST	11.50
Total	**$241.50**

GST # R106953920

** Includes criminal record check*

_____ _____
Date Applicant signature

APPLICATION FOR PRE-REGISTRATION

CANADA - NEW PHARMACY TECHNICIAN GRADUATE

Notarized Identification

APPLICANT INFORMATION

Applicant name _____

Photo

Required Documents

Passport photograph, taken within one year, affixed to space provided.

Copy of name change or marriage certificate if name on any document is different from legal name.

Required identification - one primary and one secondary.

Identification presented to the Notary Public must be the **original** document issued by the government agency. Photocopies are acceptable only if certified by the issuing government agency to be true copies of the original.

PRIMARY		SECONDARY	
Document type	*Document number*	*Document type*	*Document number*
☐ Birth certificate		☐ Passport	
☐ Canadian citizen card		☐ Valid Canadian driver's license	
☐ Canadian identity card		☐ British Columbia identification card	
		☐ Naturalization certificate	
		☐ Canadian Forces identification	

_____ Date

_____ Applicant signature

NOTARY PUBLIC CERTIFICATION

I hereby verify that the person shown in the photograph affixed on this page is the same person:

- Whose name appears as the Applicant.
- Whose identity has been proven to my satisfaction through presentation of the identification indicated.
- Whose signature on this document was signed in my presence.

_____ Date

_____ Notary signature

Notary name _____

SEAL

Address _____

_____

Tel _____

APPLICATION FOR PRE-REGISTRATION

CANADA - NEW PHARMACY TECHNICIAN GRADUATE

Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)* :

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC.

- *a charge relating to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs, or relating to any criminal offense;*
- *a finding of guilt in relation to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above is not true (i.e. if any of the above boxes is not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

_____ Date

_____ Applicant signature

APPLICATION FOR PRE-REGISTRATION

CANADA - NEW PHARMACY TECHNICIAN GRADUATE

Criminal Record Check Authorization

APPLICANT INFORMATION

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Mailing address _____
Street *City/town* *Province/State* *Postal Code*

_____ Contact phone _____
Country *Area code*

Gender ☐ Male ☐ Female B.C. Driver License _____

Birth date _____ Birthplace _____
(YYY-MM-DD *City/town* *Province/State* *Country*

Other names used or have used *(e.g. maiden name, birth name, previous married name)*

1. _____
Surname *First name* *Middle name*
2. _____
Surname *First name* *Middle name*
3. _____ _____
Surname *First name* *Middle name*

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA)

The information requested on this form is collected under the authority of the Criminal Records Review Act and in the case of child care facilities, the Community Care Facility Act, and the regulations which govern both these acts. The information provided will be used to fulfill the requirements of the Criminal Records Review Act for the release of criminal records information and is in compliance with the FOIPPA.

CONSENT FOR RELEASE OF INFORMATION AND ACKNOWLEDGEMENTS

Pursuant to the B.C. *Criminal Records Review Act*

- I hereby consent to a check for records of criminal convictions to determine whether I have a conviction or outstanding charge for any relevant offences under the Criminal Records Review Act.
- I hereby authorize the release to the Deputy Registrar any documents in the custody of the police, the court and crown counsel relating to an outstanding charge or conviction of any relevant offence as defined under the Criminal Records Review Act.
- Where the results of this check indicate that a criminal record or outstanding charge for a relevant offence may exist, I agree to provide my fingerprints to verify any such criminal record.
- The Deputy Registrar will notify me and my organization that I have an outstanding charge or conviction for any relevant offence(s) and the matter has been referred to the Deputy Registrar.
- The Deputy Registrar will determine whether or not I present a risk to physical or sexual abuse to children.
- The Deputy Registrar's determination will be disclosed to my organization and it will include consideration of any relevant offence for which I have received a pardon.
- If I am charged with or convicted of a relevant offence at any time subsequent to the criminal record check authorized herein, I further agree to report the charge or conviction to my organization and provide my organization, in a timely manner, with a new-signed Consent to a Criminal Record Check form.

"Deputy Registrar" means a person appointed under the Public Service Act *as deputy registrar for the purposes of this Act.*

☐ I have read and understood the Consent for Release of Information and Acknowledgements above. I hereby consent to these terms as indicated by my signature below.

☐ I hereby authorize the College of Pharmacists of British Columbia to conduct criminal record checks on an ongoing basis every five years. I understand that I may withdraw this consent for future criminal record checks.

_____ _____
Date Applicant signature

APPLICATION FOR
TEMPORARY PHARMACY TECHNICIAN REGISTRATION

APPLICANT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Name _____
Last name (Surname) *First name* *Other name(s)*

Address _____ Tel *(home)* _____

_____ Tel *(work)* _____

_____ Email _____
City *Province*

_____
Postal code *Country*

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Registration fee	105.00
GST	5.25
Total	**$110.25**

GST # R106953920

I attest that I am in compliance with the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

I have professional liability insurance that meets the following criteria:

- ☐ Provides a minimum of $2 million coverage.
- ☐ Provides occurrence based coverage or claims made with extended reporting period of at least 3 years.
- ☐ If not in the pharmacy technician's name, the group policy covers the pharmacy technician as an individual.

I have signed and attached:

- ☐ Statutory Declaration *(use form on page 2).*
- ☐ Pharmacy Technician Confidentiality Undertaking *(use form on page 3).*

_____ _____
Date Applicant signature

APPLICATION FOR

TEMPORARY PHARMACY TECHNICIAN REGISTRATION

Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)* :

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

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- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above is not true (i.e. if any of the above boxes is not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

_____ _____

Date Applicant signature

APPLICATION FOR

TEMPORARY PHARMACY TECHNICIAN REGISTRATION

Pharmacy Technician Confidentiality Undertaking

I agree to access the **PharmaNet** clinical and patient database through the in-pharmacy computer system, on the following terms and conditions:

- ☐ I will not access or use any clinical or patient information in the PharmaNet database or the in-Pharmacy computer system for any purpose other than those authorized by the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act and the Bylaws of the College of Pharmacists of BC made pursuant to these Acts.

- ☐ I agree at all times to treat as confidential all information referred to in paragraph (1) and will not participate in or permit, the unauthorized release, publication or disclosure of the said information to any person, corporation or other entity under any circumstances except as authorized by the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act and the Bylaws of the College of Pharmacists of BC made pursuant to these Acts.

- ☐ I agree at all times, to treat as confidential all information relating to the security and management of the PharmaNet database and the in-pharmacy computer system.

- ☐ I agree to be bound by the provisions of this agreement and will continue to do so following termination of employment in the pharmacy for any reason.

- ☐ I agree to adhere to all policies and procedures issued by the pharmacy manager and/or the pharmacy owner, consistent with legislation, policies, procedures and standards issued by the College of Pharmacists of British Columbia or the Province of British Columbia, related to the confidentiality, privacy and security of the patient or clinical information contained in the PharmaNet database and the in-pharmacy computer database.

_____ Date

_____ Applicant signature

Note:

1. *Attach original with application for registration.*
2. *Make a copy for the pharmacy manager - to be retained in the pharmacy files.*

APPLICATION FOR
NON-PRACTISING PHARMACIST REGISTRATION

APPLICANT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr **Reg #** _____

Name _____
Last name (Surname) *First name* *Other name(s)*

Address _____ Tel *(home)* _____

_____ Tel *(work)* _____

_____ Email _____
City *Province*

_____
Postal code *Country*

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Registration fee	504.00
GST	25.20
Total	**$529.20**

GST # R106953920

I attest that I am in compliance with the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

I have signed and attached:

☐ Statutory Declaration *(use form on page 2).*

☐ Criminal Record Check Authorization *(use form on page 3).*

_____ _____
Date Applicant signature

APPLICATION FOR

NON-PRACTISING PHARMACIST REGISTRATION

Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

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☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

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- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above is not true (i.e. if any of the above boxes is not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

_____ Date

_____ Applicant signature

APPLICATION FOR
NON-PRACTISING PHARMACIST REGISTRATION

Criminal Record Check Authorization

APPLICANT INFORMATION

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Mailing address _____
Street *City/town* *Province/State* *Postal Code*

_____ Contact phone _____
Country *Area code*

Gender ☐ Male ☐ Female B.C. Driver License _____

Birth date _____ Birthplace _____
YYYY-MM-DD *City/town* *Province/State* *Country*

Other names used or have used *(e.g. maiden name, birth name, previous married name)*

1. _____
Surname *First name* *Middle name*
2. _____
Surname *First name* *Middle name*
3. _____
Surname *First name* *Middle name*

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA)

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CONSENT FOR RELEASE OF INFORMATION AND ACKNOWLEDGEMENTS

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- I hereby consent to a check for records of criminal convictions to determine whether I have a conviction or outstanding charge for any relevant offences under the Criminal Records Review Act.
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- Where the results of this check indicate that a criminal record or outstanding charge for a relevant offence may exist, I agree to provide my fingerprints to verify any such criminal record.
- The Deputy Registrar will notify me and my organization that I have an outstanding charge or conviction for any relevant offence(s) and the matter has been referred to the Deputy Registrar.
- The Deputy Registrar will determine whether or not I present a risk to physical or sexual abuse to children.
- The Deputy Registrar's determination will be disclosed to my organization and it will include consideration of any relevant offence for which I have received a pardon.
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☐ I have read and understood the Consent for Release of Information and Acknowledgements above. I hereby consent to these terms as indicated by my signature below.

☐ I hereby authorize the College of Pharmacists of British Columbia to conduct criminal record checks on an ongoing basis every five years. I understand that I may withdraw this consent for future criminal record checks.

_____ _____
Date Applicant signature

APPLICATION FOR
NON-PRACTISING PHARMACY TECHNICIAN REGISTRATION

APPLICANT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr **Reg #** _____

Name _____
Last name (Surname) *First name* *Other name(s)*

Address _____ Tel *(home)* _____

_____ Tel *(work)* _____

_____ Email _____
City *Province*

_____
Postal code *Country*

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Registration fee	336.00
GST	16.80
Total	**$352.80**

GST # R106953920

I attest that I am in compliance with the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

I have signed and attached:

☐ Statutory Declaration *(use form on page 2).*

☐ Criminal Record Check Authorization *(use form on page 3).*

_____ _____
Date Applicant signature

APPLICATION FOR

NON-PRACTISING PHARMACY TECHNICIAN REGISTRATION

Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

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b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

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_____ Date

_____ Applicant signature

APPLICATION FOR
NON-PRACTISING PHARMACY TECHNICIAN REGISTRATION

Criminal Record Check Authorization

APPLICANT INFORMATION

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Mailing address _____
Street *City/town* *Province/State* *Postal Code*

_____ Contact phone _____
Country *Area code*

Gender ☐ Male ☐ Female B.C. Driver License _____

Birth date _____ Birthplace _____
(YYYY-MM-DD *City/town* *Province/State* *Country*

Other names used or have used *(e.g. maiden name, birth name, previous married name)*

1. _____
Surname *First name* *Middle name*
2. _____
Surname *First name* *Middle name*
3. _____ _____
Surname *First name* *Middle name*

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA)

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- Where the results of this check indicate that a criminal record or outstanding charge for a relevant offence may exist, I agree to provide my fingerprints to verify any such criminal record.
- The Deputy Registrar will notify me and my organization that I have an outstanding charge or conviction for any relevant offence(s) and the matter has been referred to the Deputy Registrar.
- The Deputy Registrar will determine whether or not I present a risk to physical or sexual abuse to children.
- The Deputy Registrar's determination will be disclosed to my organization and it will include consideration of any relevant offence for which I have received a pardon.
- If I am charged with or convicted of a relevant offence at any time subsequent to the criminal record check authorized herein, I further agree to report the charge or conviction to my organization and provide my organization, in a timely manner, with a new-signed Consent to a Criminal Record Check form.

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☐ I hereby authorize the College of Pharmacists of British Columbia to conduct criminal record checks on an ongoing basis every five years. I understand that I may withdraw this consent for future criminal record checks.

_____ _____
Date Applicant signature

PHARMACIST REGISTRATION RENEWAL

eServices ID

Dear ,

REGISTRATION EXPIRY:

For your upcoming renewal, we are pleased to enclose your registration renewal package:

- Registration & payment option p.1
- Profile update – contact & education information p.2
- Profile update – employment information p.3
- Statutory & insurance declaration p.4

Pages 1 to 4 must be completed, signed, and returned with payment to the College office on or before midnight of the expiry date. If your employer pays your fee, you must submit page 1 to your employer for inclusion with their payment and return pages 2 - 4.

For your convenience, online renewal is available by ***eServices*** on the college website *(see back of page 1 for more information)*.

Important Note: PDAP's CE Requirement tied to Registration Renewal

You must complete the Continuing Education (CE) component of the College's Professional Development and Assessment Program (PDAP) in order to maintain your eligibility to renew. Further details regarding this requirement are available by logging into eServices from the College website (www.bcpharmacists.org) and selecting PDAP from the main menu.

over >>>

PHARMACIST REGISTRATION RENEWAL

Cont...

Non-Practising Registration Category *(HPA bylaw, section 48)*

To transfer to this category, select "Non-Practising Pharmacist" registration option on page 1. You will need to complete, sign and return the full renewal package including the criminal record check authorization. You will not need professional liability insurance.

Former Category

To transfer to this category, select the "Former Pharmacist" option, sign, and return page 1. You will not need to complete or return pages 2 to 4. However, if there are changes to your contact information, update and return page 2.

If you have any questions or comments, please feel free to contact:

Doris Wong
Administrative Assistant – Renewals & Records
(604) 676-4224 or doris.wong@bcpharmacists.org

Yours truly,

Registrar

To protect the public by ensuring that College registrants provide safe and effective pharmacy care to help people achieve better health.

PHARMACIST REGISTRATION RENEWAL

Reg #	expires

eServices ID

REGISTRATION OPTION FOR NEXT YEAR

Registration option *(select only **one** option)*

	FEE	GST	TOTAL
☐ Full pharmacist *(years 1 to 5)*	$682.50	+ $34.13 =	**$716.63**
☐ Full pharmacist *(years 6+)*	$630.00	+ $31.50 =	**$661.50**
☐ Non-practising pharmacist	$504.00	+ $25.20 =	**$529.20**
☐ Former pharmacist *(with newsletter)*	$105.00	+ $ 5.25 =	**$110.25**
☐ Former pharmacist *(without newsletter)*	$0.00		

$ _____

TOTAL $

GST # R106953920

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder name _____

Cardholder signature _____

I attest that I am in compliance with the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

Date _____ Registrant signature _____

ONLINE RENEWAL

Go to www.bcpharmacists.org > eServices

Three easy and convenient ways to renew and/or pay online

1. Complete your renewal online and pay by credit card online:

- Go to *www.bcpharmacists.org* > *eServices* and follow the prompts to log-on and to complete your renewal and payment.
- You do not have to return any renewal documents to the college office.

2. Complete your renewal online and pay by cheque or credit card:

- Go to *www.bcpharmacists.org* > *eServices* and follow the prompts to log-on and to complete your renewal.
- Complete and sign page 1 of the renewal package. Mail this page together with your cheque or credit card information to the college office.
- You do not have to return pages 2-5.

3. Complete your renewal online and your employer pays:

- Go to *www.bcpharmacists.org* > *eServices* and follow the prompts to log-on and to complete your renewal.
- Complete and sign page 1 of the renewal package. Give this page to your employer for inclusion with their cheque.
- You do not have to return pages 2-5.

PHARMACIST REGISTRATION RENEWAL

Profile Update

You must immediately notify the College office of any changes to your contact information, employment information, and any other registration information previously provided *(HPA bylaw, section 54).*

eServices ID

CONTACT INFORMATION

	CURRENT INFORMATION	UPDATE IF NECESSARY
Send mail to my *	■ **home** address ☐ **work** address	☐ **home** address ☐ **work** address
Mailing address *		*Address 1* *Address 2* *City* *Province* *Postal code* *Country*
Email *		
Tel (Home) *		
Tel (Work)		

* denotes required information

EDUCATION

Basic education in pharmacy

☐ Diploma ☐ Baccalaureate ☐ Masters ☐ PharmD

University

Graduation year

Province/State *Country*

Highest post-basic education in pharmacy

☐ Baccalaureate ☐ Masters ☐ PharmD ☐ Doctorate

☐ Accredited residency - Hospital ☐ Accredited residency - Community

University

Graduation year

Province/State *Country*

If changes are made in this section, you must submit supporting documents (e.g. copy of degree or completion certificate).

PHARMACIST REGISTRATION RENEWAL

Profile Update

eServices ID

EMPLOYMENT

EMPLOYMENT STATUS:

- ☐ A. Employed in the profession of pharmacy ***(provide details below)***
- ☐ B. Employed in other than the profession of pharmacy, seeking employment in the profession of pharmacy
- ☐ C. Employed in other than the profession of pharmacy, not seeking employment in the profession of pharmacy
- ☐ D. Unemployed and seeking employment in the profession of pharmacy
- ☐ E. Unemployed and not seeking employment in the profession of pharmacy

Primary	Secondary	Third
Pharmacare # _____	*Pharmacare #* _____	*Pharmacare #* _____
Employer name	Employer name	Employer name
Prov / Postal code	Prov / Postal code	Prov / Postal code
Country	Country	Country
CATEGORY: ☐ Permanent employee ☐ Casual employee ☐ Temporary employee ☐ Self employed	**CATEGORY:** ☐ Permanent employee ☐ Casual employee ☐ Temporary employee ☐ Self employed	**CATEGORY:** ☐ Permanent employee ☐ Casual employee ☐ Temporary employee ☐ Self employed
POSITION: ☐ Director of Pharmacy ☐ Pharmacy Owner/Manager ☐ Pharmacy Manager ☐ Researcher ☐ Staff Pharmacist ☐ Pharmacist Consultant ☐ Educator ☐ Industrial Pharmacist ☐ Institutional Leader/Coordinator ☐ Other	**POSITION:** ☐ Director of Pharmacy ☐ Pharmacy Owner/Manager ☐ Pharmacy Manager ☐ Researcher ☐ Staff Pharmacist ☐ Pharmacist Consultant ☐ Educator ☐ Industrial Pharmacist ☐ Institutional Leader/Coordinator ☐ Other	**POSITION:** ☐ Director of Pharmacy ☐ Pharmacy Owner/Manager ☐ Pharmacy Manager ☐ Researcher ☐ Staff Pharmacist ☐ Pharmacist Consultant ☐ Educator ☐ Industrial Pharmacist ☐ Institutional Leader/Coordinator ☐ Other
WEEKLY PRACTICE HOURS: ☐ 40 and above ☐ 15 - 29 ☐ 30 - 39 ☐ 14 or less	**WEEKLY PRACTICE HOURS:** ☐ 40 and above ☐ 15 - 29 ☐ 30 - 39 ☐ 14 or less	**WEEKLY PRACTICE HOURS:** ☐ 40 and above ☐ 15 - 29 ☐ 30 - 39 ☐ 14 or less
PLACE OF EMPLOYMENT: ☐ Hospital and other health care facilities ■ Community pharmacy ☐ Other pharmacy ☐ Group professional practice/clinic ☐ Community health centre ☐ Other community-based pharmacist practice ☐ Post-secondary educational institution ☐ Association/government/para-governmental ☐ Health-related industry/manufacturing/commercial ☐ Community pharmacy corporate office ☐ Other	**PLACE OF EMPLOYMENT:** ☐ Hospital and other health care facilities ☐ Community pharmacy ☐ Other pharmacy ☐ Group professional practice/clinic ☐ Community health centre ☐ Other community-based pharmacist practice ☐ Post-secondary educational institution ☐ Association/government/para-governmental ☐ Health-related industry/manufacturing/commercial ☐ Community pharmacy corporate office ☐ Other	**PLACE OF EMPLOYMENT:** ☐ Hospital and other health care facilities ☐ Community pharmacy ☐ Other pharmacy ☐ Group professional practice/clinic ☐ Community health centre ☐ Other community-based pharmacist practice ☐ Post-secondary educational institution ☐ Association/government/para-governmental ☐ Health-related industry/manufacturing/commercial ☐ Community pharmacy corporate office ☐ Other

PHARMACIST REGISTRATION RENEWAL

eServices ID

Statutory & Insurance Declaration

STATUTORY DECLARATION (FORM 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)*:

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC.

- *a charge relating to an offense under any Act regulating the practice of pharmacy or relating to the sale of drugs, or relating to any criminal offense;*
- *a finding of guilt in relation to an offense under any Act regulating the practice of pharmacy or relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above are not true (i.e. if any of the above boxes are not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

PROFESSIONAL LIABILITY INSURANCE

☐ I have professional liability insurance that meets the following criteria:
- Provides a minimum of $2 million coverage.
- Provides occurrence based coverage or claims made with extended reporting period of at least 3 years.
- If not in the pharmacists' name, the group policy covers the pharmacist as an individual.

☐ Not applicable to me (I am currently in Non-Practising pharmacist category).

I declare the facts set out herein to be true.

_____ _____

Date Applicant signature

LIMITED PHARMACIST REGISTRATION RENEWAL

eServices ID

Dear ,

REGISTRATION EXPIRY:

For your upcoming renewal, we are pleased to enclose your registration renewal package:

- Registration & payment option p.1
- Profile update – contact & education information p.2
- Profile update – employment information p.3
- Statutory & insurance declaration p.4

Pages 1 to 4 must be completed, signed, and returned with payment to the College office on or before midnight of the expiry date. If your employer pays your fee, you must submit page 1 to your employer for inclusion with their payment and return pages 2 - 4.

IMPORTANT - TIMELY RESPONSE REQUIRED:

Please be advised that failure for the College to receive your completed renewal package, including payment, on or before your registration expiry date will result in an automated transfer of your status on the College register from 'active' to 'inactive'(HPA Bylaw 51(5)).

There are a number of significant and immediate consequences as a result of this including the cancellation of your access to PharmaNet, which could take up to two business days to reactivate, and the potential that your liability insurance would be null and void. In addition you will be subject to the current late registration and reinstatement fee of $131.25 plus applicable taxes (HPA Bylaw 53(d)).

over >>>

LIMITED PHARMACIST REGISTRATION RENEWAL

Cont...

Former Category

To transfer to this category, select the "Former Pharmacist" option, sign, and return page 1. You will not need to complete or return pages 2 to 4. However, if there are changes to your contact information, update and return page 2.

If you have any questions or comments, please feel free to contact:

Doris Wong
Administrative Assistant – Records
(604) 676-4224 or doris.wong@bcpharmacists.org

Yours truly,

Registrar

To protect the public by ensuring British Columbia pharmacists provide safe and effective pharmacy care to help people achieve better health.

LIMITED PHARMACIST REGISTRATION RENEWAL

Reg #	expires

eServices ID

REGISTRATION OPTION FOR NEXT YEAR

Registration option *(select only **one** option)*

	FEE	GST	TOTAL
☐ Limited pharmacist	$682.50	+ $34.13	= **$716.63**

$_____

$_____

$_____

TOTAL $

GST # R106953920

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder name _____

Cardholder signature _____

I attest that I am in compliance with the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

_____ Date

_____ Registrant signature

LIMITED PHARMACIST REGISTRATION RENEWAL

Profile Update

You must immediately notify the College office of any changes to your contact information, employment information, and any other registration information previously provided *(HPA bylaw, section 54).*

eServices ID

CONTACT INFORMATION

	CURRENT INFORMATION	**UPDATE IF NECESSARY**
Send mail to my *	■ **home** address ☐ **work** address	☐ **home** address ☐ **work** address
Mailing address *		*Address 1* *Address 2* *City* *Province* *Postal code* *Country*
Email *		
Tel (Home) *		
Tel (Work)		

* denotes required information

EDUCATION

Basic education in pharmacy

☐ Diploma ☐ Baccalaureate ☐ Masters PharmD

University

Graduation year

Province/State *Country*

Highest post-basic education in pharmacy

☐ Baccalaureate ☐ Masters ☐ PharmD ☐ Doctorate

☐ Accredited residency - Hospital ☐ Accredited residency - Community

University

Graduation year

Province/State *Country*

If changes are made in this section, you must submit supporting documents (e.g. copy of degree or completion certificate).

LIMITED PHARMACIST REGISTRATION RENEWAL

Profile Update

eServices ID

EMPLOYMENT

EMPLOYMENT STATUS:

A. Employed in the profession of pharmacy ***(provide details below)***

☐ B. Employed in other than the profession of pharmacy, seeking employment in the profession of pharmacy

☐ C. Employed in other than the profession of pharmacy, not seeking employment in the profession of pharmacy

☐ D. Unemployed and seeking employment in the profession of pharmacy

☐ E. Unemployed and not seeking employment in the profession of pharmacy

Primary	Secondary	Third
Pharmacare # _____	*Pharmacare #* _____	*Pharmacare #* _____
Employer name	Employer name	Employer name
Prov / Postal code	Prov / Postal code	Prov / Postal code
Country	Country	Country
CATEGORY: ☒ Permanent employee ☐ Casual employee ☐ Temporary employee ☐ Self employed	**CATEGORY:** ☐ Permanent employee ☐ Casual employee ☐ Temporary employee ☐ Self employed	**CATEGORY:** ☐ Permanent employee ☐ Casual employee ☐ Temporary employee ☐ Self employed
POSITION: ☐ Director of Pharmacy ☐ Pharmacy Owner/Manager ☐ Pharmacy Manager ☐ Researcher ☐ Staff Pharmacist ☐ Pharmacist Consultant ☒ Educator ☐ Industrial Pharmacist ☐ Institutional Leader/Coordinator ☐ Other	**POSITION:** ☐ Director of Pharmacy ☐ Pharmacy Owner/Manager ☐ Pharmacy Manager ☐ Researcher ☐ Staff Pharmacist ☐ Pharmacist Consultant ☐ Educator ☐ Industrial Pharmacist ☐ Institutional Leader/Coordinator ☐ Other	**POSITION:** ☐ Director of Pharmacy ☐ Pharmacy Owner/Manager ☐ Pharmacy Manager ☐ Researcher ☐ Staff Pharmacist ☐ Pharmacist Consultant ☐ Educator ☐ Industrial Pharmacist ☐ Institutional Leader/Coordinator ☐ Other
WEEKLY PRACTICE HOURS: ☐ 40 and above ☐ 15 - 29 ☒ 30 - 39 ☐ 14 or less	**WEEKLY PRACTICE HOURS:** ☐ 40 and above ☐ 15 - 29 ☐ 30 - 39 ☐ 14 or less	**WEEKLY PRACTICE HOURS:** ☐ 40 and above ☐ 15 - 29 ☐ 30 - 39 ☐ 14 or less
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LIMITED PHARMACIST REGISTRATION RENEWAL

eServices ID

Statutory & Insurance Declaration

STATUTORY DECLARATION (FORM 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)*:

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC.

- *a charge relating to an offense under any Act regulating the practice of pharmacy or relating to the sale of drugs, or relating to any criminal offense;*
- *a finding of guilt in relation to an offense under any Act regulating the practice of pharmacy or relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above are not true (i.e. if any of the above boxes are not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

PROFESSIONAL LIABILITY INSURANCE

☐ I have professional liability insurance that meets the following criteria:
- Provides a minimum of $2 million coverage.
- Provides occurrence based coverage or claims made with extended reporting period of at least 3 years.
- If not in the pharmacists' name, the group policy covers the pharmacist as an individual.

☐ Not applicable to me (I am currently in Non-Practising pharmacist category).

I declare the facts set out herein to be true.

_____ _____

Date Applicant signature

NON-PRACTISING PHARMACIST REGISTRATION RENEWAL

eServices ID

Dear ,

REGISTRATION EXPIRY:

For your upcoming renewal, we are pleased to enclose your registration renewal package:

- Registration & payment option p.1
- Profile update – contact & education information p.2
- Profile update – employment information p.3
- Statutory & insurance declaration p.4

Pages 1 to 4 must be completed, signed, and returned with payment to the College office on or before midnight of the expiry date. If your employer pays your fee, you must submit page 1 to your employer for inclusion with their payment and return pages 2-4.

Late Fee and Reinstatement *(HPA bylaw, sections 52 and 53)*
You will be subject to the terms of late fee and reinstatement if completed renewal package is not received before registration expiry.

Former Category
To transfer to this category, select the "Former Pharmacist" option, sign, and return page 1. You will not need to complete or return pages 2 to 4. However, if there are changes to your contact information, update and return page 2.

If you have any questions or comments, please feel free to contact:

Doris Wong
Administrative Assistant – Renewals & Records
(604) 676-4224 or doris.wong@bcpharmacists.org

Yours truly,

Registrar

NON-PRACTISING PHARMACIST REGISTRATION RENEWAL

Reg #	expires

eServices ID

REGISTRATION OPTION FOR NEXT YEAR

Registration option *(select only **one** option)*

	FEE		GST		TOTAL
☐ Non-practising pharmacist	$ 504.00	+	$ 25.20	=	**$ 529.20**
☐ Former pharmacist *(with newsletter)*	$ 105.00	+	$ 5.25	=	**$ 110.25**
☐ Former pharmacist *(without newsletter)*	$ 0.00				

$_____

TOTAL $

GST # R106953920

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder name _____

Cardholder signature _____

I attest that I am in compliance with the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

_____ Date

_____ Registrant signature

NON-PRACTISING PHARMACIST REGISTRATION RENEWAL

Profile Update

You must immediately notify the College office of any changes to your contact information, employment information, and any other registration information previously provided *(HPA bylaw, section 54).*

eServices ID

CONTACT INFORMATION

	CURRENT INFORMATION	UPDATE IF NECESSARY
Send mail to my *	■ **home** address ☐ **work** address	☐ **home** address ☐ **work** address
Mailing address *		*Address 1* *Address 2* *City* *Province* *Postal code* *Country*
Email *		
Tel (Home) *		
Tel (Work)		

* denotes required information

EDUCATION

Basic education in pharmacy

☐ Diploma ☐ Baccalaureate ☐ Masters ☐ PharmD

University

Graduation year

Province/State *Country*

Highest post-basic education in pharmacy

☐ Baccalaureate ☐ Masters ☐ PharmD ☐ Doctorate

☐ Accredited residency - Hospital ☐ Accredited residency - Community

University

Graduation year

Graduation year *Country*

If changes are made in this section, you must submit supporting documents (e.g. copy of degree or completion certificate).

NON-PRACTISING PHARMACIST REGISTRATION RENEWAL

Profile Update

eServices ID

EMPLOYMENT

EMPLOYMENT STATUS:

- ☐ A. Employed in the profession of pharmacy ***(provide details below)***
- ☐ B. Employed in other than the profession of pharmacy, seeking employment in the profession of pharmacy
- ☐ C. Employed in other than the profession of pharmacy, not seeking employment in the profession of pharmacy
- ☐ D. Unemployed and seeking employment in the profession of pharmacy
- ☐ E. Unemployed and not seeking employment in the profession of pharmacy

Primary	Secondary	Third
Pharmacare # _____	*Pharmacare #* _____	*Pharmacare #* _____
Employer name	Employer name	Employer name
Prov / Postal code	Prov / Postal code	Prov / Postal code
Country	Country	Country
CATEGORY: ☐ Permanent employee ☐ Casual employee ☐ Temporary employee ☐ Self employed	**CATEGORY:** ☐ Permanent employee ☐ Casual employee ☐ Temporary employee ☐ Self employed	**CATEGORY:** ☐ Permanent employee ☐ Casual employee ☐ Temporary employee ☐ Self employed
POSITION: ☐ Director of Pharmacy ☐ Pharmacy Owner/Manager ☐ Pharmacy Manager ☐ Researcher ☐ Staff Pharmacist ☐ Pharmacist Consultant ☐ Educator ☐ Industrial Pharmacist ☐ Institutional Leader/Coordinator ☐ Other	**POSITION:** ☐ Director of Pharmacy ☐ Pharmacy Owner/Manager ☐ Pharmacy Manager ☐ Researcher ☐ Staff Pharmacist ☐ Pharmacist Consultant ☐ Educator ☐ Industrial Pharmacist ☐ Institutional Leader/Coordinator ☐ Other	**POSITION:** ☐ Director of Pharmacy ☐ Pharmacy Owner/Manager ☐ Pharmacy Manager ☐ Researcher ☐ Staff Pharmacist ☐ Pharmacist Consultant ☐ Educator ☐ Industrial Pharmacist ☐ Institutional Leader/Coordinator ☐ Other
WEEKLY PRACTICE HOURS: ☐ 40 and above ☐ 15 - 29 ☐ 30 - 39 ☐ 14 or less	**WEEKLY PRACTICE HOURS:** ☐ 40 and above ☐ 15 - 29 ☐ 30 - 39 ☐ 14 or less	**WEEKLY PRACTICE HOURS:** ☐ 40 and above ☐ 15 - 29 ☐ 30 - 39 ☐ 14 or less
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NON-PRACTISING PHARMACIST REGISTRATION RENEWAL

Statutory & Insurance Declaration

eServices ID

STATUTORY DECLARATION (FORM 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

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☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC.

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- *a finding of guilt in relation to an offense under any Act regulating the practice of pharmacy or relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above are not true (i.e. if any of the above boxes are not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

PROFESSIONAL LIABILITY INSURANCE

☐ I have professional liability insurance that meets the following criteria:
- Provides a minimum of $2 million coverage.
- Provides occurrence based coverage or claims made with extended reporting period of at least 3 years.
- If not in the pharmacists' name, the group policy covers the pharmacist as an individual.

☐ Not applicable to me (I am currently in Non-Practising pharmacist category).

I declare the facts set out herein to be true.

_____ _____

Date Applicant signature

UBC STUDENT REGISTRATION RENEWAL

eServices ID

Dear

REGISTRATION EXPIRY:

Please be advised your registration is up for renewal. The online process is automated, updated in real time and available 24/7, resulting in reduced resource requirements and increased efficiency for the College and its registrants. Your upcoming renewal must be completed online by following the steps below.

1. **Go to www.bcpharmacists.org**
2. **Select eServices and follow prompts to login**
   (NOTE: Your eServices ID is shown above)
3. **Select Renew Registration**
4. **Follow the prompts to complete your renewal**

The full renewal process, including payment, must be completed and received by the College on or before midnight of your expiry date. If you have any questions or comments, please feel free to contact:

Doris Wong
Administrative Assistant – Renewals & Records
(604) 676-4224 or doris.wong@bcpharmacists.org

Yours truly,

IMPORTANT - TIMELY RESPONSE REQUIRED:

Please be advised that failure for the College to receive your completed renewal package, including payment, on or before your registration expiry date will result in an automated transfer of your status on the College register from 'active' to 'inactive'(HPA Bylaw 51(5)). In addition, you will be subject to the current late registration and reinstatement fee of $52.50 plus applicable taxes (HPA Bylaw 53(d)).

UBC STUDENT REGISTRATION RENEWAL

Reg #	expires

eServices ID

REGISTRATION OPTION FOR NEXT YEAR

Registration option *(select only **one** option)*

	FEE		GST		TOTAL
☐ UBC student pharmacist	$52.50	+	$2.63	=	**$55.13**

$ _____

TOTAL $

GST # R106953920

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder name _____

Cardholder signature _____

I attest that I am in compliance with the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

Date _____ Registrant signature _____

UBC STUDENT REGISTRATION RENEWAL

Profile Update

You must immediately notify the College office of any changes to your contact information, employment information, and any other registration information previously provided *(HPA bylaw, section 54).*

eServices ID

CONTACT INFORMATION

	CURRENT INFORMATION	UPDATE IF NECESSARY
Send mail to my *	■ **home** address ☐ **work** address	☐ **home** address ☐ **work** address
Mailing address *		*Address 1* *Address 2* *City* *Province* *Postal code* *Country*
Email *		
Tel (Home) *		
Tel (Work)		

* denotes required information

EDUCATION

Basic education in pharmacy

☐ Diploma ☐ Baccalaureate ☐ Masters ☐ PharmD

University

Graduation year

Province/State *Country*

Highest post-basic education in pharmacy

☐ Baccalaureate ☐ Masters ☐ PharmD ☐ Doctorate

☐ Accredited residency - Hospital ☐ Accredited residency - Community

University

Graduation year

Province/State *Country*

If changes are made in this section, you must submit supporting documents (e.g. copy of degree or completion certificate).

UBC STUDENT REGISTRATION RENEWAL

Profile Update

eServices ID

EMPLOYMENT

EMPLOYMENT STATUS:

- ☐ A. Employed in the profession of pharmacy ***(provide details below)***
- ☐ B. Employed in other than the profession of pharmacy, seeking employment in the profession of pharmacy
- ☐ C. Employed in other than the profession of pharmacy, not seeking employment in the profession of pharmacy
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- ☐ E. Unemployed and not seeking employment in the profession of pharmacy

Primary	Secondary	Third
Pharmacare # _____	*Pharmacare #* _____	*Pharmacare #* _____
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Prov / Postal code	Prov / Postal code	Prov / Postal code
Country	Country	Country
CATEGORY: ☐ Permanent employee ☐ Casual employee ☐ Temporary employee ☐ Self employed	**CATEGORY:** ☐ Permanent employee ☐ Casual employee ☐ Temporary employee ☐ Self employed	**CATEGORY:** ☐ Permanent employee ☐ Casual employee ☐ Temporary employee ☐ Self employed
POSITION: ☐ Director of Pharmacy ☐ Pharmacy Owner/Manager ☐ Pharmacy Manager ☐ Researcher ☐ Staff Pharmacist ☐ Pharmacist Consultant ☐ Educator ☐ Industrial Pharmacist ☐ Institutional Leader/Coordinator ☐ Other	**POSITION:** ☐ Director of Pharmacy ☐ Pharmacy Owner/Manager ☐ Pharmacy Manager ☐ Researcher ☐ Staff Pharmacist ☐ Pharmacist Consultant ☐ Educator ☐ Industrial Pharmacist ☐ Institutional Leader/Coordinator ☐ Other	**POSITION:** ☐ Director of Pharmacy ☐ Pharmacy Owner/Manager ☐ Pharmacy Manager ☐ Researcher ☐ Staff Pharmacist ☐ Pharmacist Consultant ☐ Educator ☐ Industrial Pharmacist ☐ Institutional Leader/Coordinator ☐ Other
WEEKLY PRACTICE HOURS: ☐ 40 and above ☐ 15 - 29 ☐ 30 - 39 ☐ 14 or less	**WEEKLY PRACTICE HOURS:** ☐ 40 and above ☐ 15 - 29 ☐ 30 - 39 ☐ 14 or less	**WEEKLY PRACTICE HOURS:** ☐ 40 and above ☐ 15 - 29 ☐ 30 - 39 ☐ 14 or less
PLACE OF EMPLOYMENT: ☐ Hospital and other health care facilities ■ Community pharmacy ☐ Other pharmacy ☐ Group professional practice/clinic ☐ Community health centre ☐ Other community-based pharmacist practice ☐ Post-secondary educational institution ☐ Association/government/para-governmental ☐ Health-related industry/manufacturing/commercial ☐ Community pharmacy corporate office ☐ Other	**PLACE OF EMPLOYMENT:** ☐ Hospital and other health care facilities ☐ Community pharmacy ☐ Other pharmacy ☐ Group professional practice/clinic ☐ Community health centre ☐ Other community-based pharmacist practice ☐ Post-secondary educational institution ☐ Association/government/para-governmental ☐ Health-related industry/manufacturing/commercial ☐ Community pharmacy corporate office ☐ Other	**PLACE OF EMPLOYMENT:** ☐ Hospital and other health care facilities ☐ Community pharmacy ☐ Other pharmacy ☐ Group professional practice/clinic ☐ Community health centre ☐ Other community-based pharmacist practice ☐ Post-secondary educational institution ☐ Association/government/para-governmental ☐ Health-related industry/manufacturing/commercial ☐ Community pharmacy corporate office ☐ Other

UBC STUDENT REGISTRATION RENEWAL

eServices ID

Statutory & Insurance Declaration

STATUTORY DECLARATION (FORM 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)*:

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC.

- *a charge relating to an offense under any Act regulating the practice of pharmacy or relating to the sale of drugs, or relating to any criminal offense;*
- *a finding of guilt in relation to an offense under any Act regulating the practice of pharmacy or relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above are not true (i.e. if any of the above boxes are not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

PROFESSIONAL LIABILITY INSURANCE

☐ I have professional liability insurance that meets the following criteria:

- Provides a minimum of $2 million coverage.
- Provides occurrence based coverage or claims made with extended reporting period of at least 3 years.
- If not in the pharmacists' name, the group policy covers the pharmacist as an individual.

Not applicable to me (I am currently a UBC student pharmacist).

I declare the facts set out herein to be true.

_____ _____

Date Applicant signature

PHARMACY TECHNICIAN REGISTRATION RENEWAL

eServices ID

,

Dear ,

REGISTRATION EXPIRY:

For your upcoming renewal, we are pleased to enclose your registration renewal package:

- Registration & payment option p.1
- Profile update – contact & education information p.2
- Profile update – employment information p.3
- Statutory & insurance declaration p.4

Pages 1 to 4 must be completed, signed, and returned with payment to the College office on or before midnight of the expiry date. If your employer pays your fee, you must submit page 1 to your employer for inclusion with their payment and return pages 2 - 4.

For your convenience, online renewal is available by ***eServices*** on the college website *(see back of page 1 for more information)* .

Important Note: PDAP's CE Requirement tied to Registration Renewal

You must complete the Continuing Education (CE) component of the College's Professional Development and Assessment Program (PDAP) in order to maintain your eligibility to renew. Further details regarding this requirement are available by logging into eServices from the College website (www.bcpharmacists.org) and selecting PDAP from the main menu.

over >>>

PHARMACY TECHNICIAN REGISTRATION RENEWAL

Cont...

Non-Practising Registration Category *(HPA bylaw, section 48)*

To transfer to this category, select "Non-Practising Pharmacy Technician" registration option on page 1. You will need to complete, sign and return the full renewal package. You will not need professional liability insurance.

Former Category

To transfer to this category, select the "Former Pharmacy Technician" option, sign, and return page 1. You will not need to complete or return pages 2 to 4. However, if there are changes to your contact information, update and return page 2.

If you have any questions or comments, please feel free to contact:

Doris Wong
Administrative Assistant – Renewals & Records
(604) 676-4224 or doris.wong@bcpharmacists.org

Yours truly,

Registrar

To protect the public by ensuring that College registrants provide safe and effective pharmacy care to help people achieve better health.

PHARMACY TECHNICIAN REGISTRATION RENEWAL

Reg # expires

eServices ID

REGISTRATION OPTION FOR NEXT YEAR

Registration option *(select only **one** option)*

	FEE		GST		TOTAL
☐ Full pharmacy technician	$420.00	+	$21.00	=	$441.00
☐ Non-practising pharmacy technician	$336.00	+	$16.80	=	$352.80
☐ Former pharmacy technician *(with newsletter)*	$105.00	+	$ 5.25	=	**$110.25**
☐ Former pharmacy technician *(without newsletter)*	$ 0.00				

$_____

TOTAL $

GST # R106953920

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder name _____

Cardholder signature _____

I attest that I am in compliance with the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

_____ Date

_____ Registrant signature

ONLINE RENEWAL

Go to www.bcpharmacists.org > eServices

Three easy and convenient ways to renew and/or pay online

1. Complete your renewal online and pay by credit card online:

- Go to *www.bcpharmacists.org* > *eServices* and follow the prompts to log-on and to complete your renewal and payment.
- You do not have to return any renewal documents to the college office.

2. Complete your renewal online and pay by cheque or credit card:

- Go to *www.bcpharmacists.org* > *eServices* and follow the prompts to log-on and to complete your renewal.
- Complete and sign page 1 of the renewal package. Mail this page together with your cheque or credit card information to the college office.
- You do not have to return pages 2-4.

3. Complete your renewal online and your employer pays:

- Go to *www.bcpharmacists.org* > *eServices* and follow the prompts to log-on and to complete your renewal.
- Complete and sign page 1 of the renewal package. Give this page to your employer for inclusion with their cheque.
- You do not have to return pages 2-4.

PHARMACIST REGISTRATION RENEWAL

Profile Update

You must immediately notify the College office of any changes to your contact information, employment information, and any other registration information previously provided
(HPA bylaw, section 54).

eServices ID

CONTACT INFORMATION

	CURRENT INFORMATION	UPDATE IF NECESSARY
Send mail to my *	☐ **home** address ☐ **work** address	☐ **home** address ☐ **work** address
Mailing address *		*Address 1* *Address 2* *City* *Province* *Postal code* *Country*
Email *		
Tel (Home) *		
Tel (Work)		

* denotes required information

EDUCATION

Basic education in pharmacy

☐ Diploma ☐ Baccalaureate ☐ Masters ☐ PharmD

University

Graduation year

Province/State *Country*

Highest post-basic education in pharmacy

☐ Baccalaureate ☐ Masters ☐ PharmD ☐ Doctorate

☐ Accredited residency - Hospital ☐ Accredited residency - Community

University

Graduation year

Province/State *Country*

If changes are made in this section, you must submit supporting documents (e.g. copy of degree or completion certificate).

PHARMACIST REGISTRATION RENEWAL

Profile Update

eServices ID

EMPLOYMENT

EMPLOYMENT STATUS:

- ☐ A. Employed in the profession of pharmacy ***(provide details below)***
- ☐ B. Employed in other than the profession of pharmacy, seeking employment in the profession of pharmacy
- ☐ C. Employed in other than the profession of pharmacy, not seeking employment in the profession of pharmacy
- ☐ D. Unemployed and seeking employment in the profession of pharmacy
- ☐ E. Unemployed and not seeking employment in the profession of pharmacy

Primary	Secondary	Third
Pharmacare # _____	*Pharmacare #* _____	*Pharmacare #* _____
Employer name	Employer name	Employer name
Prov / Postal code	Prov / Postal code	Prov / Postal code
Country	Country	Country
CATEGORY: ☐ Permanent employee ☐ Casual employee ☐ Temporary employee ☐ Self employed	**CATEGORY:** ☐ Permanent employee ☐ Casual employee ☐ Temporary employee ☐ Self employed	**CATEGORY:** ☐ Permanent employee ☐ Casual employee ☐ Temporary employee ☐ Self employed
POSITION: ☐ Director of Pharmacy ☐ Pharmacy Owner/Manager ☐ Pharmacy Manager ☐ Researcher ☐ Staff Pharmacist ☐ Pharmacist Consultant ☐ Educator ☐ Industrial Pharmacist ☐ Institutional Leader/Coordinator ☐ Other	**POSITION:** ☐ Director of Pharmacy ☐ Pharmacy Owner/Manager ☐ Pharmacy Manager ☐ Researcher ☐ Staff Pharmacist ☐ Pharmacist Consultant ☐ Educator ☐ Industrial Pharmacist ☐ Institutional Leader/Coordinator ☐ Other	**POSITION:** ☐ Director of Pharmacy ☐ Pharmacy Owner/Manager ☐ Pharmacy Manager ☐ Researcher ☐ Staff Pharmacist ☐ Pharmacist Consultant ☐ Educator ☐ Industrial Pharmacist ☐ Institutional Leader/Coordinator ☐ Other
WEEKLY PRACTICE HOURS: ☐ 40 and above ☐ 15 - 29 ☐ 30 - 39 ☐ 14 or less	**WEEKLY PRACTICE HOURS:** ☐ 40 and above ☐ 15 - 29 ☐ 30 - 39 ☐ 14 or less	**WEEKLY PRACTICE HOURS:** ☐ 40 and above ☐ 15 - 29 ☐ 30 - 39 ☐ 14 or less
PLACE OF EMPLOYMENT: ☐ Hospital and other health care facilities ☐ Community pharmacy ☐ Other pharmacy ☐ Group professional practice/clinic ☐ Community health centre ☐ Other community-based pharmacist practice ☐ Post-secondary educational institution ☐ Association/government/para-governmental ☐ Health-related industry/manufacturing/commercial ☐ Community pharmacy corporate office ☐ Other	**PLACE OF EMPLOYMENT:** ☐ Hospital and other health care facilities ☐ Community pharmacy ☐ Other pharmacy ☐ Group professional practice/clinic ☐ Community health centre ☐ Other community-based pharmacist practice ☐ Post-secondary educational institution ☐ Association/government/para-governmental ☐ Health-related industry/manufacturing/commercial ☐ Community pharmacy corporate office ☐ Other	**PLACE OF EMPLOYMENT:** ☐ Hospital and other health care facilities ☐ Community pharmacy ☐ Other pharmacy ☐ Group professional practice/clinic ☐ Community health centre ☐ Other community-based pharmacist practice ☐ Post-secondary educational institution ☐ Association/government/para-governmental ☐ Health-related industry/manufacturing/commercial ☐ Community pharmacy corporate office ☐ Other

PHARMACY TECHNICIAN REGISTRATION RENEWAL

eServices ID

Statutory & Insurance Declaration

STATUTORY DECLARATION (FORM 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)*:

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC.

- *a charge relating to an offense under any Act regulating the practice of pharmacy or relating to the sale of drugs, or relating to any criminal offense;*
- *a finding of guilt in relation to an offense under any Act regulating the practice of pharmacy or relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above are not true (i.e. if any of the above boxes are not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty imposed
d. Extenuating circumstances you wish taken into account for your application.

PROFESSIONAL LIABILITY INSURANCE

☐ I have professional liability insurance that meets the following criteria:
- Provides a minimum of $2 million coverage.
- Provides occurrence based coverage or claims made with extended reporting period of at least 3 years.
- If not in the pharmacists' name, the group policy covers the pharmacist as an individual.

☐ Not applicable to me (I am currently in Non-Practising pharmacy technician category).

I declare the facts set out herein to be true.

_____ _____

Date Applicant signature

NON-PRACTISING PHARMACY TECHNICIAN REGISTRATION RENEWAL

eServices ID

Dear ,

REGISTRATION EXPIRY:

For your upcoming renewal, we are pleased to enclose your registration renewal package:

- Registration & payment option p.1
- Profile update – contact & education information p.2
- Profile update – employment information p.3
- Statutory & insurance declaration p.4

Pages 1 to 4 must be completed, signed, and returned with payment to the College office on or before midnight of the expiry date. If your employer pays your fee, you must submit page 1 to your employer for inclusion with their payment and return pages 2-4.

Late Fee and Reinstatement *(HPA bylaw, sections 52 and 53)*
You will be subject to the terms of late fee and reinstatement if completed renewal package is not received before registration expiry.

Former Category
To transfer to this category, select the "Former Pharmacy Technician" option, sign, and return page 1. You w
not need to complete or return pages 2 to 4. However, if there are changes to your contact information, update and return page 2.

If you have any questions or comments, please feel free to contact:

Doris Wong
Administrative Assistant – Renewals & Records
(604) 676-4224 or doris.wong@bcpharmacists.org

Yours truly,

Registrar

NON-PRACTISING PHARMACY TECHNICIAN REGISTRATION RENEWAL

Reg # expires

eServices ID

REGISTRATION OPTION FOR NEXT YEAR

Registration option *(select only **one** option)*

	FEE	GST	TOTAL
☐ Non-practising pharmacy technician	$ 336.00	+ $ 16.80 =	**$ 352.80**
☐ Former pharmacy technician *(with newsletter)*	$ 105.00	+ $5.25 =	$110.25
☐ Former pharmacy technician *(without newsletter)*	$ 0.00		

$_____

TOTAL $

GST # R106953920

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder name _____

Cardholder signature _____

I attest that I am in compliance with the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

_____ Date

_____ Registrant signature

NON-PRACTISING PHARMACY TECHNICIAN REGISTRATION RENEWAL

Profile Update

You must immediately notify the College office of any changes to your contact information, employment information, and any other registration information previously provided *(HPA bylaw, section 54).*

eServices ID

CONTACT INFORMATION

	CURRENT INFORMATION	UPDATE IF NECESSARY
Send mail to my *	■ **home** address ☐ **work** address	☐ **home** address ☐ **work** address
Mailing address *		*Address 1* *Address 2* *City* *Province* *Postal code* *Country*
Email *		
Tel (Home) *		
Tel (Work)		

* denotes required information

EDUCATION

Basic education in pharmacy

☐ Diploma ☐ Baccalaureate ☐ Masters ☐ PharmD

University

Graduation year

Province/State *Country*

Highest post-basic education in pharmacy

☐ Baccalaureate ☐ Masters ☐ PharmD ☐ Doctorate

☐ Accredited residency - Hospital ☐ Accredited residency - Community

University

Graduation year

Graduation year *Country*

If changes are made in this section, you must submit supporting documents (e.g. copy of degree or completion certificate).

NON-PRACTISING PHARMACY TECHNICIAN REGISTRATION RENEWAL

Profile Update

eServices ID

EMPLOYMENT

EMPLOYMENT STATUS:

- ☐ A. Employed in the profession of pharmacy ***(provide details below)***
- ☐ B. Employed in other than the profession of pharmacy, seeking employment in the profession of pharmacy
- ☐ C. Employed in other than the profession of pharmacy, not seeking employment in the profession of pharmacy
- ☐ D. Unemployed and seeking employment in the profession of pharmacy
- ☐ E. Unemployed and not seeking employment in the profession of pharmacy

Primary	Secondary	Third
Pharmacare # _____	*Pharmacare #* _____	*Pharmacare #* _____
Employer name	Employer name	Employer name
Prov / Postal code	Prov / Postal code	Prov / Postal code
Country	Country	Country
CATEGORY: ☐ Permanent employee ☐ Casual employee ☐ Temporary employee ☐ Self employed	**CATEGORY:** ☐ Permanent employee ☐ Casual employee ☐ Temporary employee ☐ Self employed	**CATEGORY:** ☐ Permanent employee ☐ Casual employee ☐ Temporary employee ☐ Self employed
POSITION: ☐ Director of Pharmacy ☐ Pharmacy Owner/Manager ☐ Pharmacy Manager ☐ Researcher ☐ Staff Pharmacist ☐ Pharmacist Consultant ☐ Educator ☐ Industrial Pharmacist ☐ Institutional Leader/Coordinator ☐ Other	**POSITION:** ☐ Director of Pharmacy ☐ Pharmacy Owner/Manager ☐ Pharmacy Manager ☐ Researcher ☐ Staff Pharmacist ☐ Pharmacist Consultant ☐ Educator ☐ Industrial Pharmacist ☐ Institutional Leader/Coordinator ☐ Other	**POSITION:** ☐ Director of Pharmacy ☐ Pharmacy Owner/Manager ☐ Pharmacy Manager ☐ Researcher ☐ Staff Pharmacist ☐ Pharmacist Consultant ☐ Educator ☐ Industrial Pharmacist ☐ Institutional Leader/Coordinator ☐ Other
WEEKLY PRACTICE HOURS: ☐ 40 and above ☐ 15 - 29 ☐ 30 - 39 ☐ 14 or less	**WEEKLY PRACTICE HOURS:** ☐ 40 and above ☐ 15 - 29 ☐ 30 - 39 ☐ 14 or less	**WEEKLY PRACTICE HOURS:** ☐ 40 and above ☐ 15 - 29 ☐ 30 - 39 ☐ 14 or less
PLACE OF EMPLOYMENT: ☐ Hospital and other health care facilities ☐ Community pharmacy ☐ Other pharmacy ☐ Group professional practice/clinic ☐ Community health centre ☐ Other community-based pharmacist practice ☐ Post-secondary educational institution ☐ Association/government/para-governmental ☐ Health-related industry/manufacturing/commercial ☐ Community pharmacy corporate office ☐ Other	**PLACE OF EMPLOYMENT:** ☐ Hospital and other health care facilities ☐ Community pharmacy ☐ Other pharmacy ☐ Group professional practice/clinic ☐ Community health centre ☐ Other community-based pharmacist practice ☐ Post-secondary educational institution ☐ Association/government/para-governmental ☐ Health-related industry/manufacturing/commercial ☐ Community pharmacy corporate office ☐ Other	**PLACE OF EMPLOYMENT:** ☐ Hospital and other health care facilities ☐ Community pharmacy ☐ Other pharmacy ☐ Group professional practice/clinic ☐ Community health centre ☐ Other community-based pharmacist practice ☐ Post-secondary educational institution ☐ Association/government/para-governmental ☐ Health-related industry/manufacturing/commercial ☐ Community pharmacy corporate office ☐ Other

NON-PRACTISING PHARMACY TECHNICIAN REGISTRATION RENEWAL

Statutory & Insurance Declaration

eServices ID

STATUTORY DECLARATION (FORM 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)*:

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC.

- *a charge relating to an offense under any Act regulating the practice of pharmacy or relating to the sale of drugs, or relating to any criminal offense;*
- *a finding of guilt in relation to an offense under any Act regulating the practice of pharmacy or relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above are not true (i.e. if any of the above boxes are not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

PROFESSIONAL LIABILITY INSURANCE

☐ I have professional liability insurance that meets the following criteria:
- Provides a minimum of $2 million coverage.
- Provides occurrence based coverage or claims made with extended reporting period of at least 3 years.
- If not in the pharmacy technicians' name, the group policy covers the pharmacy technician as an individual.

☐ Not applicable to me (I am currently in Non-Practising pharmacy technician category).

I declare the facts set out herein to be true.

_____ _____

Date Applicant signature

Form 11A

APPLICATION FOR REINSTATEMENT

Late Registration Renewal

- ☐ Full Pharmacist
- ☐ Non-Practising Pharmacist
- ☐ Limited Pharmacist
- ☐ Pharmacy Technician
- ☐ Non-Practising Pharmacy Technician

CONTACT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Address _____ Tel (home) _____

_____ Tel (work) _____

_____ Email _____
City *Province*

_____
Postal code *Country*

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____ /____

Cardholder name _____

Cardholder signature _____

Late renewal fee	131.25
GST	6.56
Total	**$137.81**

GST # R106953920

I have completed and attached my annual registration renewal form together with the necessary fees.

_____ Date

_____ Applicant signature

APPLICATION FOR REINSTATEMENT

LESS THAN 6 YEARS IN NON-PRACTISING OR FORMER PHARMACIST REGISTER

CHECKLIST

You must submit

1. ☐ Checklist *(page 1)*.
2. ☐ Application form *(page 2)*.
3. ☐ Notarized identification *(use form on page 3)*.
4. ☐ Statutory declaration *(use form on page 4)*.
5. ☐ Criminal record check authorization *(use form on page 5)*.

You must submit IF

6. ☐ Evidence of your authorization to work in Canada – if you are not a Canadian citizen or a permanent resident. Acceptable documents: Canadian citizenship card, Canadian passport, permanent resident card, social insurance card, or work permit.
7. ☐ A letter/certificate of standing from **each** regulatory body - if you have engaged in the practice of pharmacy or another health profession in another jurisdiction. Letter/certificate must be dated within three months prior to the date of the application and must be mailed to the college office directly from the regulatory bodies.

Photocopy both sides of documents where applicable.
Documents in a language other than English must be translated by a government official or an official translator.

APPLICATION FOR REINSTATEMENT

LESS THAN 6 YEARS IN NON-PRACTISING OR FORMER PHARMACIST REGISTER

Application Form

CONTACT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Address _____

_____

_____
City *Province*

_____ _____
Postal code *Country*

Tel *(home)* _____

Tel *(work)* _____

Email _____

REQUIRED FEES

☐ Reinstatement fee.
☐ Criminal Record Check fee.
☐ PDAP Knowledge Assessment (KA) fee.*

* *The full amount can be applied towards your annual registration fee if you meet the PDAP standards and reinstate within one year of this application.*

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*
☐ VISA ☐ MasterCard

Card # _____ Exp ____ /____

Cardholder name _____

Cardholder signature _____

Reinstatement fee *	282.50
PDAP KA fee	525.00
GST	40.38
Total	**$847.88**

GST # R106953920

* *Includes criminal record check*

☐ I hereby authorize the release of my PDAP status in support of this application for reinstatement.

_____ _____
Date Applicant signature

APPLICATION FOR REINSTATEMENT

LESS THAN 6 YEARS IN NON-PRACTISING OR FORMER PHARMACIST REGISTER

Notarized Identification

APPLICANT INFORMATION

Applicant name _____

Photo

Required Documents

Passport photograph, taken within one year, affixed to space provided.

Copy of name change or marriage certificate if name on any document is different from legal name.

Required identification - one primary and one secondary.

Identification presented to the Notary Public must be the **original** document issued by the government agency. Photocopies are acceptable only if certified by the issuing government agency to be true copies of the original.

PRIMARY		SECONDARY	
Document type	*Document number*	*Document type*	*Document number*
☐ Birth certificate		☐ Passport	
☐ Canadian citizen card		☐ Valid Canadian driver's license	
☐ Canadian identity card		☐ British Columbia identification card	
		☐ Naturalization certificate	
		☐ Canadian Forces identification	

_____ Date

_____ Applicant signature

NOTARY PUBLIC CERTIFICATION

I hereby verify that the person shown in the photograph affixed on this page is the same person:

- Whose name appears as the Applicant.
- Whose identity has been proven to my satisfaction through presentation of the identification indicated.
- Whose signature on this document was signed in my presence.

_____ Date

_____ Notary signature

Notary name _____

SEAL

Address _____

_____

Tel _____

APPLICATION FOR REINSTATEMENT

LESS THAN 6 YEARS IN NON-PRACTISING OR FORMER PHARMACIST REGISTER

Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)* :

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC.

- *a charge relating to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs, or relating to any criminal offense;*
- *a finding of guilt in relation to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above is not true (i.e. if any of the above boxes is not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

_____ Date

_____ Applicant signature

APPLICATION FOR REINSTATEMENT
LESS THAN 6 YEARS IN NON-PRACTISING OR FORMER PHARMACIST REGISTER

Criminal Record Check Authorization

APPLICANT INFORMATION

Legal name _____
Last name (Surname) First name Other name(s)

Mailing address _____
Street City/town Province/State Postal Code

_____ Contact phone _____
Country Area code

Gender ☐ Male ☐ Female B.C. Driver License _____

Birth date _____ Birthplace _____
YYYY-MM-DD City/town Province/State Country

Other names used or have used *(e.g. maiden name, birth name, previous married name)*

1. _____
Surname First name Middle name
2. _____
Surname First name Middle name
3. _____
Surname First name Middle name

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA)

The information requested on this form is collected under the authority of the Criminal Records Review Act and in the case of child care facilities, the Community Care Facility Act, and the regulations which govern both these acts. The information provided will be used to fulfill the requirements of the Criminal Records Review Act for the release of criminal records information and is in compliance with the FOIPPA.

CONSENT FOR RELEASE OF INFORMATION AND ACKNOWLEDGEMENTS

Pursuant to the B.C. *Criminal Records Review Act*

- I hereby consent to a check for records of criminal convictions to determine whether I have a conviction or outstanding charge for any relevant offences under the Criminal Records Review Act.
- I hereby authorize the release to the Deputy Registrar any documents in the custody of the police, the court and crown counsel relating to an outstanding charge or conviction of any relevant offence as defined under the Criminal Records Review Act
- Where the results of this check indicate that a criminal record or outstanding charge for a relevant offence may exist, I agree to provide my fingerprints to verify any such criminal record.
- The Deputy Registrar will notify me and my organization that I have an outstanding charge or conviction for any relevant offence(s) and the matter has been referred to the Deputy Registrar.
- The Deputy Registrar will determine whether or not I present a risk to physical or sexual abuse to children.
- The Deputy Registrar's determination will be disclosed to my organization and it will include consideration of any relevant offence for which I have received a pardon.
- If I am charged with or convicted of a relevant offence at any time subsequent to the criminal record check authorized herein, I further agree to report the charge or conviction to my organization and provide my organization, in a timely manner, with a new-signed Consent to a Criminal Record Check form.

"Deputy Registrar" means a person appointed under the Public Service Act *as deputy registrar for the purposes of this Act.*

☐ I have read and understood the Consent for Release of Information and Acknowledgements above. I hereby consent to these terms as indicated by my signature below.

☐ I hereby authorize the College of Pharmacists of British Columbia to conduct criminal record checks on an ongoing basis every five years. I understand that I may withdraw this consent for future criminal record checks.

_____ _____
Date Applicant signature

APPLICATION FOR REINSTATEMENT

6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACIST REGISTER

CHECKLIST

You must submit

1. ☐ Checklist *(page 1)*.
2. ☐ Application form *(page 2)*.
3. ☐ Notarized identification *(use form on page 3)*.
4. ☐ Certification of Pharmacy Related Employment *(use form on page 4; one form per employer)*.
5. ☐ Statutory declaration *(use form on page 5)*.
6. ☐ Criminal record check authorization *(use form on page 6)*.

You must submit IF

7. ☐ Evidence of your authorization to work in Canada – if you are not a Canadian citizen or a permanent resident. Acceptable documents: Canadian citizenship card, Canadian passport, permanent resident card, social insurance card, or work permit.
8. ☐ A letter/certificate of standing from **each** regulatory body - if you have engaged in the practice of pharmacy or another health profession in another jurisdiction. Letter/certificate must be dated within three months prior to the date of the application and must be mailed to the college office directly from the regulatory bodies.

Photocopy both sides of documents where applicable.
Documents in a language other than English must be translated by a government official or an official translator.

APPLICATION FOR REINSTATEMENT

6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACIST REGISTER

Application Form

CONTACT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Address _____ Tel *(home)* _____

_____ Tel *(work)* _____

_____ Email _____
City *Province*

_____
Postal code *Country*

REQUIRED FEES

☐ Reinstatement fee.

☐ Criminal Record Check fee.

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card #_____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Application fee *	282.50
GST	14.13
Total	**$296.63**

GST # R106953920

** Includes criminal record check*

☐ I hereby authorize the release of my PDAP status in support of this application for reinstatement

_____ _____
Date Applicant signature

APPLICATION FOR REINSTATEMENT

6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACIST REGISTER

Notarized Identification

APPLICANT INFORMATION

Applicant name _____

Photo

Required Documents

Passport photograph, taken within one year, affixed to space provided.

Copy of name change or marriage certificate if name on any document is different from legal name.

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Document type	*Document number*	*Document type*	*Document number*
☐ Birth certificate		☐ Passport	
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☐ Canadian identity card		☐ British Columbia identification card	
		☐ Naturalization certificate	
		☐ Canadian Forces identification	

_____ Date

_____ Applicant signature

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_____ Date

_____ Notary signature

Notary name _____

SEAL

Address _____

_____

Tel _____

APPLICATION FOR REINSTATEMENT

6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACIST REGISTER

Certification of Pharmacy Related Employment

EMPLOYMENT INFORMATION

Applicant name _____

Employer name _____

Address _____

_____

_____

Tel _____ Fax _____

Position _____ Total hours worked _____

Start date _____ End date _____

EMPLOYER CERTIFICATION

I certify that the above employment information is correct.

Name _____

Position _____

Pharmacy Manager / Pharmacy Owner / Human Resources Manager

_____ _____

Date Employer signature

APPLICATION FOR REINSTATEMENT

6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACIST REGISTER

Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
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WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)* :

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

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☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

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- *a finding of guilt in relation to an offense under any Act, in any jurisdiction, regulating the practice of pharmacy or any other health profession relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above is not true (i.e. if any of the above boxes is not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

_____ Date

_____ Applicant signature

APPLICATION FOR REINSTATEMENT

6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACIST REGISTER

Criminal Record Check Authorization

APPLICANT INFORMATION

Legal name _____
Last name (Surname) First name Other name(s)

Mailing address _____
Street City/town Province/State Postal Code

_____ Contact phone _____
Country Area code

Gender ☐ Male ☐ Female B.C. Driver License _____

Birth date _____ Birthplace _____
YYYY-MM-DD City/town Province/State Country

Other names used or have used *(e.g. maiden name, birth name, previous married name)*

1. _____
Surname First name Middle name
2. _____
Surname First name Middle name
3. _____
Surname First name Middle name

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- I hereby consent to a check for records of criminal convictions to determine whether I have a conviction or outstanding charge for any relevant offences under the Criminal Records Review Act.
- I hereby authorize the release to the Deputy Registrar any documents in the custody of the police, the court and crown counsel relating to an outstanding charge or conviction of any relevant offence as defined under the Criminal Records Review Act
- Where the results of this check indicate that a criminal record or outstanding charge for a relevant offence may exist, I agree to provide my fingerprints to verify any such criminal record.
- The Deputy Registrar will notify me and my organization that I have an outstanding charge or conviction for any relevant offence(s) and the matter has been referred to the Deputy Registrar.
- The Deputy Registrar will determine whether or not I present a risk to physical or sexual abuse to children.
- The Deputy Registrar's determination will be disclosed to my organization and it will include consideration of any relevant offence for which I have received a pardon.
- If I am charged with or convicted of a relevant offence at any time subsequent to the criminal record check authorized herein, I further agree to report the charge or conviction to my organization and provide my organization, in a timely manner, with a new-signed Consent to a Criminal Record Check form.

"Deputy Registrar" means a person appointed under the Public Service Act *as deputy registrar for the purposes of this Act.*

☐ I have read and understood the Consent for Release of Information and Acknowledgements above. I hereby consent to these terms as indicated by my signature below.

☐ I hereby authorize the College of Pharmacists of British Columbia to conduct criminal record checks on an ongoing basis every five years. I understand that I may withdraw this consent for future criminal record checks.

_____ _____
Date Applicant signature

Form 11D

APPLICATION FOR REINSTATEMENT

Late Registration Renewal

☐ UBC Student Pharmacist

CONTACT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Address _____ Tel (home) _____

_____ Tel (work) _____

_____ Email _____
City *Province*

_____
Postal code *Country*

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____ /____

Cardholder name _____

Cardholder signature _____

Late renewal fee	52.50
GST	2.63
Total	**$55.13**

GST # R106953920

I have completed and attached my annual registration renewal form together with the necessary fees.

_____ Date

_____ Applicant signature

APPLICATION FOR REINSTATEMENT

90 DAYS OR MORE ON INACTIVE STUDENT REGISTER

CHECKLIST

You must submit

1. ☐ Checklist *(page 1)*.
2. ☐ Application form *(page 2)*.
3. ☐ Copy of letter from UBC confirming registration with Faculty of Pharmacy.
4. ☐ Notarized identification *(use form on page 3)*.
5. ☐ Statutory declaration *(use form on page 4)*.
6. ☐ Criminal record check authorization *(use form on page 5)*.

You must submit IF

7. ☐ Evidence of your authorization to work in Canada – if you are not a Canadian citizen or a permanent resident. Acceptable documents: Canadian citizenship card, Canadian passport, permanent resident card, social insurance card, or work permit.
8. ☐ A letter/certificate of standing from **each** regulatory body - if you have engaged in the practice of pharmacy or another health profession in another jurisdiction. Letter/certificate must be dated within three months prior to the date of the application and must be mailed to the college office directly from the regulatory bodies.

Photocopy both sides of documents where applicable.
Documents in a language other than English must be translated by a government official or an official translator.

APPLICATION FOR REINSTATEMENT

90 DAYS OR MORE ON INACTIVE STUDENT REGISTER

Application Form

CONTACT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Address _____ Tel *(home)* _____

_____ Tel *(work)* _____

_____ Email _____
City *Province*

_____
Postal code *Country*

REQUIRED FEES

☐ Reinstatement/renewal fee.

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card #_____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Application fee *	52.50
GST	2.63
Total	**$55.13**

GST # R106953920

** Includes criminal record check*

_____
Date

_____
Applicant signature

APPLICATION FOR REINSTATEMENT

90 DAYS OR MORE ON INACTIVE STUDENT REGISTER

Notarized Identification

APPLICANT INFORMATION

Applicant name _____

Photo

Required Documents

Passport photograph, taken within one year, affixed to space provided.

Copy of name change or marriage certificate if name on any document is different from legal name.

Required identification - one primary and one secondary.

Identification presented to the Notary Public must be the **original** document issued by the government agency. Photocopies are acceptable only if certified by the issuing government agency to be true copies of the original.

PRIMARY		SECONDARY	
Document type	*Document number*	*Document type*	*Document number*
☐ Birth certificate		☐ Passport	
☐ Canadian citizen card		☐ Valid Canadian driver's license	
☐ Canadian identity card		☐ British Columbia identification card	
		☐ Naturalization certificate	
		☐ Canadian Forces identification	

_____ Date

_____ Applicant signature

NOTARY PUBLIC CERTIFICATION

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- Whose identity has been proven to my satisfaction through presentation of the identification indicated.
- Whose signature on this document was signed in my presence.

_____ Date

_____ Notary signature

Notary name _____

SEAL

Address _____

_____

Tel _____

APPLICATION FOR REINSTATEMENT

90 DAYS OR MORE ON INACTIVE STUDENT REGISTER

Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)* :

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☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

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☐ 5. I am a person of good character.

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a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

_____ Date

_____ Applicant signature

APPLICATION FOR REINSTATEMENT

90 DAYS OR MORE ON INACTIVE STUDENT REGISTER

Criminal Record Check Authorization

APPLICANT INFORMATION

Legal name _____
Last name (Surname) First name Other name(s)

Mailing address _____
Street City/town Province/State Postal Code

_____ Contact phone _____
Country Area code

Gender ☐ Male ☐ Female B.C. Driver License _____

Birth date _____ Birthplace _____
YYYY-MM-DD City/town Province/State Country

Other names used or have used *(e.g. maiden name, birth name, previous married name)*

1. _____
Surname First name Middle name
2. _____
Surname First name Middle name
3. _____
Surname First name Middle name

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA)

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- Where the results of this check indicate that a criminal record or outstanding charge for a relevant offence may exist, I agree to provide my fingerprints to verify any such criminal record.
- The Deputy Registrar will notify me and my organization that I have an outstanding charge or conviction for any relevant offence(s) and the matter has been referred to the Deputy Registrar.
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_____ _____
Date Applicant signature

APPLICATION FOR REINSTATEMENT

LESS THAN 6 YEARS IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN REGISTER

CHECKLIST

You must submit

1. ☐ Checklist *(page 1)*.
2. ☐ Application form *(page 2)*.
3. ☐ Notarized identification *(use form on page 3)*.
4. ☐ Statutory declaration *(use form on page 4)*.
5. ☐ Criminal record check authorization *(use form on page 5)*.

You must submit IF

6. ☐ Evidence of your authorization to work in Canada – if you are not a Canadian citizen or a permanent resident. Acceptable documents: Canadian citizenship card, Canadian passport, permanent resident card, social insurance card, or work permit.
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Photocopy both sides of documents where applicable.
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APPLICATION FOR REINSTATEMENT

LESS THAN 6 YEARS IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN REGISTER

Application Form

CONTACT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Address _____

_____

_____
City *Province*

_____
Postal code *Country*

Tel *(home)* _____

Tel *(work)* _____

Email _____

REQUIRED FEES

☐ Reinstatement fee.

☐ Criminal Record Check fee.

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Reinstatement fee *	177.50
GST	8.88
Total	**$186.38**

GST # R106953920

* *Includes criminal record check*

☐ I hereby authorize the release of my PDAP status in support of this application for reinstatement

_____ _____
Date Applicant signature

APPLICATION FOR REINSTATEMENT

LESS THAN 6 YEARS IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN REGISTER

Notarized Identification

APPLICANT INFORMATION

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Copy of name change or marriage certificate if name on any document is different from legal name.

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Document type	*Document number*	*Document type*	*Document number*
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_____ Date

_____ Notary signature

Notary name _____

SEAL

Address _____

_____

Tel _____

APPLICATION FOR REINSTATEMENT

LESS THAN 6 YEARS IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN REGISTER

Statutory Declaration (Form 5)

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☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC.

- *a charge relating to an offense under any Act regulating the practice of pharmacy or relating to the sale of drugs, or relating to any criminal offense;*
- *a finding of guilt in relation to an offense under any Act regulating the practice of pharmacy or relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above is not true (i.e. if any of the above boxes is not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

_____ Date

_____ Applicant signature

APPLICATION FOR REINSTATEMENT

LESS THAN 6 YEARS IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN REGISTER

Criminal Record Check Authorization

APPLICANT INFORMATION

Legal name _____
Last name (Surname) First name Other name(s)

Mailing address _____
Street City/town Province/State Postal Code

_____ Contact phone _____
Country Area code

Gender ☐ Male ☐ Female B.C. Driver License _____

Birth date _____ Birthplace _____
YYYY-MM-DD City/town Province/State Country

Other names used or have used *(e.g. maiden name, birth name, previous married name)*

1. _____
Surname First name Middle name
2. _____
Surname First name Middle name
3. _____
Surname First name Middle name

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA)

The information requested on this form is collected under the authority of the Criminal Records Review Act and in the case of child care facilities, the Community Care Facility Act, and the regulations which govern both these acts. The information provided will be used to fulfill the requirements of the Criminal Records Review Act for the release of criminal records information and is in compliance with the FOIPPA.

CONSENT FOR RELEASE OF INFORMATION AND ACKNOWLEDGEMENTS

Pursuant to the B.C. *Criminal Records Review Act*

- I hereby consent to a check for records of criminal convictions to determine whether I have a conviction or outstanding charge for any relevant offences under the Criminal Records Review Act.
- I hereby authorize the release to the Deputy Registrar any documents in the custody of the police, the court and crown counsel relating to an outstanding charge or conviction of any relevant offence as defined under the Criminal Records Review Act
- Where the results of this check indicate that a criminal record or outstanding charge for a relevant offence may exist, I agree to provide my fingerprints to verify any such criminal record.
- The Deputy Registrar will notify me and my organization that I have an outstanding charge or conviction for any relevant offence(s) and the matter has been referred to the Deputy Registrar.
- The Deputy Registrar will determine whether or not I present a risk to physical or sexual abuse to children.
- The Deputy Registrar's determination will be disclosed to my organization and it will include consideration of any relevant offence for which I have received a pardon.
- If I am charged with or convicted of a relevant offence at any time subsequent to the criminal record check authorized herein, I further agree to report the charge or conviction to my organization and provide my organization, in a timely manner, with a new-signed Consent to a Criminal Record Check form.

"Deputy Registrar" means a person appointed under the Public Service Act *as deputy registrar for the purposes of this Act.*

☐ I have read and understood the Consent for Release of Information and Acknowledgements above. I hereby consent to these terms as indicated by my signature below.

☐ I hereby authorize the College of Pharmacists of British Columbia to conduct criminal record checks on an ongoing basis every five years. I understand that I may withdraw this consent for future criminal record checks.

_____ _____
Date Applicant signature

APPLICATION FOR REINSTATEMENT

6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN REGISTER

CHECKLIST

You must submit

1. ☐ Checklist *(page 1)*.
2. ☐ Application form *(page 2)*.
3. ☐ Notarized identification *(use form on page 3)*.
4. ☐ Certification of Pharmacy Related Employment *(use form on page 4; one form per employer)*.
5. ☐ Statutory declaration *(use form on page 5)*.
6. ☐ Criminal record check authorization *(use form on page 6)*.

You must submit IF

7. ☐ Evidence of your authorization to work in Canada – if you are not a Canadian citizen or a permanent resident. Acceptable documents: Canadian citizenship card, Canadian passport, permanent resident card, social insurance card, or work permit.
8. ☐ A letter/certificate of standing from **each** regulatory body - if you have engaged in the practice of pharmacy or another health profession in another jurisdiction. Letter/certificate must be dated within three months prior to the date of the application and must be mailed to the college office directly from the regulatory bodies.

Photocopy both sides of documents where applicable.
Documents in a language other than English must be translated by a government official or an official translator.

APPLICATION FOR REINSTATEMENT

6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN REGISTER

Application Form

CONTACT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Address _____

_____

_____
City *Province*

_____
Postal code *Country*

Tel *(home)* _____

Tel *(work)* _____

Email _____

REQUIRED FEES

☐ Reinstatement fee.

☐ Criminal Record Check fee.

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card #_____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Application fee *	177.50
GST	8.86
Total	**$186.36**

GST # R106953920

** Includes criminal record check*

☐ I hereby authorize the release of my PDAP status in support of this application for reinstatement

_____ _____

Date Applicant signature

APPLICATION FOR REINSTATEMENT

6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN REGISTER

Notarized Identification

APPLICANT INFORMATION

Applicant name _____

Photo

Required Documents

Passport photograph, taken within one year, affixed to space provided.

Copy of name change or marriage certificate if name on any document is different from legal name.

Required identification - one primary and one secondary.

Identification presented to the Notary Public must be the **original** document issued by the government agency. Photocopies are acceptable only if certified by the issuing government agency to be true copies of the original.

PRIMARY		SECONDARY	
Document type	*Document number*	*Document type*	*Document number*
☐ Birth certificate		☐ Passport	
☐ Canadian citizen card		☐ Valid Canadian driver's license	
☐ Canadian identity card		☐ British Columbia identification card	
		☐ Naturalization certificate	
		☐ Canadian Forces identification	

_____ Date

_____ Applicant signature

NOTARY PUBLIC CERTIFICATION

I hereby verify that the person shown in the photograph affixed on this page is the same person:

- Whose name appears as the Applicant.
- Whose identity has been proven to my satisfaction through presentation of the identification indicated.
- Whose signature on this document was signed in my presence.

_____ Date

_____ Notary signature

Notary name _____

SEAL

Address _____

_____

Tel _____

APPLICATION FOR REINSTATEMENT

6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN REGISTER

Certification of Pharmacy Related Employment

EMPLOYMENT INFORMATION

Applicant name _____

Employer name _____

Address _____

_____

_____

Tel _____ Fax _____

Position _____ Total hours worked _____

Start date _____ End date _____

EMPLOYER CERTIFICATION

I certify that the above employment information is correct.

Name _____

Position _____
Pharmacy Manager / Pharmacy Owner / Human Resources Manager

_____ _____

Date Employer signature

APPLICATION FOR REINSTATEMENT

6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN REGISTER

Statutory Declaration (Form 5)

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF
AN APPLICATION FOR REGISTRATION
WITH THE COLLEGE OF PHARMACISTS OF BRITISH COLUMBIA

I, _____ declare that *(check the appropriate boxes)* :

☐ 1. I have not been convicted in Canada or elsewhere of any offence that, if committed by a person registered under the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act, would constitute unprofessional conduct or conduct unbecoming of a person registered under these bylaws.

☐ 2. My entitlement to practise pharmacy or any other health profession has not been limited, restricted or subject to any terms, limits or conditions or disciplinary action in any jurisdiction at any time.

☐ 3. At the present time, no investigation, review or proceeding is taking place in any jurisdiction which could result in the suspension or cancellation of my authorization to practise pharmacy or any other health profession.

☐ 4. My past conduct does not demonstrate any pattern of incompetence or untrustworthiness, which would make registration contrary to the public interest.

☐ 5. I am a person of good character.

☐ 6. I am aware of and will practice at all times in compliance with the Health Professions Act and the Pharmacy Operations and Drug Scheduling Act of British Columbia, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ 7. I shall provide the Registrar with the details of any of the following that relate to me or that occur or arise prior, during, or after my registration with the College of Pharmacists of BC.

- *a charge relating to an offense under any Act regulating the practice of pharmacy or relating to the sale of drugs, or relating to any criminal offense;*
- *a finding of guilt in relation to an offense under any Act regulating the practice of pharmacy or relating to the sale of drugs or in relation to any criminal offense;*
- *a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;*
- *a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.*

On a separate sheet of paper, provide details if any of the above is not true (i.e. if any of the above boxes is not checked off). Details to include:

a. Criminal offence/Disciplinary action/Investigation
b. Date when offence was committed/Applicable health profession/Applicable jurisdiction
c. Disposition of charge including details of penalty-imposed
d. Extenuating circumstances you wish taken into account for your application.

I declare the facts set out herein to be true.

_____ Date

_____ Applicant signature

APPLICATION FOR REINSTATEMENT

6 YEARS OR MORE IN NON-PRACTISING OR FORMER PHARMACY TECHNICIAN REGISTER

Criminal Record Check Authorization

APPLICANT INFORMATION

Legal name _____
Last name (Surname) First name Other name(s)

Mailing address _____
Street City/town Province/State Postal Code

_____ Contact phone _____
Country Area code

Gender ☐ Male ☐ Female B.C. Driver License _____

Birth date _____ Birthplace _____
YYYY-MM-DD City/town Province/State Country

Other names used or have used *(e.g. maiden name, birth name, previous married name)*

1. _____
Surname First name Middle name
2. _____
Surname First name Middle name
3. _____
Surname First name Middle name

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA)

The information requested on this form is collected under the authority of the Criminal Records Review Act and in the case of child care facilities, the Community Care Facility Act, and the regulations which govern both these acts. The information provided will be used to fulfill the requirements of the Criminal Records Review Act for the release of criminal records information and is in compliance with the FOIPPA.

CONSENT FOR RELEASE OF INFORMATION AND ACKNOWLEDGEMENTS

Pursuant to the B.C. *Criminal Records Review Act*

- I hereby consent to a check for records of criminal convictions to determine whether I have a conviction or outstanding charge for any relevant offences under the Criminal Records Review Act.
- I hereby authorize the release to the Deputy Registrar any documents in the custody of the police, the court and crown counsel relating to an outstanding charge or conviction of any relevant offence as defined under the Criminal Records Review Act
- Where the results of this check indicate that a criminal record or outstanding charge for a relevant offence may exist, I agree to provide my fingerprints to verify any such criminal record.
- The Deputy Registrar will notify me and my organization that I have an outstanding charge or conviction for any relevant offence(s) and the matter has been referred to the Deputy Registrar.
- The Deputy Registrar will determine whether or not I present a risk to physical or sexual abuse to children.
- The Deputy Registrar's determination will be disclosed to my organization and it will include consideration of any relevant offence for which I have received a pardon.
- If I am charged with or convicted of a relevant offence at any time subsequent to the criminal record check authorized herein, I further agree to report the charge or conviction to my organization and provide my organization, in a timely manner, with a new-signed Consent to a Criminal Record Check form.

"Deputy Registrar" means a person appointed under the Public Service Act *as deputy registrar for the purposes of this Act.*

☐ I have read and understood the Consent for Release of Information and Acknowledgements above. I hereby consent to these terms as indicated by my signature below.

☐ I hereby authorize the College of Pharmacists of British Columbia to conduct criminal record checks on an ongoing basis every five years. I understand that I may withdraw this consent for future criminal record checks.

_____ _____
Date Applicant signature

APPLICATION FOR
CERTIFICATION – INJECTION DRUG ADMINISTRATION

APPLICANT INFORMATION

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr Reg # _____

Legal name _____
Last name (Surname) *First name* *Other name(s)*

Address _____ Tel (*home*) _____

_____ Tel (*work*) _____

_____ Email _____
City *Province*

_____
Postal code *Country*

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____ /____

Cardholder name _____

Cardholder signature _____

Application Fee*	105.00
GST	5.25
Total	**$110.25**

GST # R106953920

Includes current year's certification fee (valid to end of current year's pharmacist registration.

I attest that I am in compliance with the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

I have attached:

- ☐ Signed Declaration Form *(page 2).*
- ☐ Copy of certificates of completion of training from a College approved accredited program in the administration of drugs by injection.
- ☐ Copy of certificates of completion of training in the administration of first aid and CPR.

_____ Date

_____ Applicant signature

APPLICATION FOR

CERTIFICATION – INJECTION DRUG ADMINISTRATION

Declaration Form

PROVINCE OF BRITISH COLUMBIA, CANADA, IN THE MATTER OF MY APPLICATION TO THE COLLEGE OF PHARMACISTS OF BC FOR CERTIFICATION – INJECTION DRUG ADMINISTRATION

I, _____ declare that *(check the appropriate boxes)* :

- ☐ 1. I am the person referred to in the documents submitted in support of my application, and that these documents present a true and accurate account of my qualifications.
- ☐ 2. I am registered as a full pharmacist with the College of Pharmacists of BC.
- ☐ 3. I will abide by the standards, limits and conditions that apply to the administration of drugs by injection and restrict my practice to those areas in which I am competent.
- ☐ 4. I have successfully completed training from a College approved accredited program in the administration of drugs by injection.
- ☐ 5. I have successfully completed training in the administration of first aid and CPR and will maintain valid first aid certification and CPR certification for the duration of my authorization, and that if I am unable to provide proof of certification, my authorization to administer injections will be cancelled.
- ☐ 6. I will engage in the restricted activity of administering drugs by injection only after having received approval from the College of Pharmacists of BC.
- ☐ 7. The status of my eligibility for certification is subject to audit and that false or misleading statements concerning my qualifications may be considered grounds for a complaint of unprofessional conduct.

I make this declaration, conscientiously as it to be true and knowing that it is of the same force and effect as if made under oath.

_____ Date

_____ Applicant signature

APPLICATION FOR NEW PHARMACY

Community

Form 1A

APPLICANT INFORMATION

☐ Corporation ☐ Sole proprietor / Partnership

Cert. of Incorporation # _____ Incorporation Date _____

Company name _____

Address _____ Tel _____

_____ Fax _____

_____ _____ Email _____

Postal code

*Director **	*Pharmacist*	*Director **	*Pharmacist*
_____	☐	_____	☐
_____	☐	_____	☐

* Majority must be BC registered pharmacists

PROPOSED PHARMACY INFORMATION

Operating name _____

Address _____ Tel _____

_____ Fax _____

_____ _____ Manager _____

Postal code

Contact ✦ _____

Opening date _____ Tel ✦ _____

Software Vendor _____ Fax ✦ _____

✦ *Only if manager not available before opening*

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____ / ____

Cardholder name _____

Cardholder signature _____

Application Fee	525.00
Initial Licence Fee	1,181.25
GST	85.31
Total	**$1,791.56**

GST # R106953920

I attest that:

☐ The Pharmacy is in compliance with the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Pharmacists Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ I have read and understood the Pharmacy Licensure in British Columbia – Information Guide and Resources package.

☐ I will maintain a valid business licence for the duration of the pharmacy licence.

_____ _____

Name (please print) Signature

_____ _____

Position Date

APPLICATION FOR NEW PHARMACY

Community

APPLICATION REQUIREMENT CHECKLIST

Application must be received by the College Office <u>at least 10 weeks</u> prior to the proposed opening date.

The following must be submitted together with this application:

- ☐ Diagram detailing the layout (see diagram requirement checklist below)
- ☐ Copy of the Certificate of Incorporation
- ☐ Copy of the certified Incorporation Application
- ☐ Copy of the certified Notice of Articles
- ☐ Copy of valid business licence

The following must be submitted at least 2 weeks prior to opening:

- ☐ Acknowledgement of Completion of Confidentiality Form

DIAGRAM REQUIREMENT CHECKLIST

The following information must be included on the diagram:

scale: ¼ inch = 1 foot

- ☐ Dispensary area size - minimum 15 m^2 (160 sq ft)
- ☐ Dispensary area counters - minimum 3 m^2 (30 sq ft)
- ☐ Storeroom space - minimum 4 m^2 (40 sq ft) of shelf space
- ☐ Description of the front counter and shelf height
- ☐ Location of the double stainless steel sink
- ☐ Location of the refrigerator
- ☐ Location and type of consultation area (semi-private or private)
- ☐ Drug storage cabinet and/or safe
- ☐ Type of security system
- ☐ Location of Professional Service Area or Schedule 2 items, if applicable
- ☐ Location of Professional Product Area or Schedule 3 items - visible and up to 7.6 m (25 ft) from dispensary, if applicable
- ☐ Location of "Medication Information" sign, if applicable

The following information must be provided:

- ☐ Description of how the professional service area is made visually distinctive or indicate location of Pharmacy signs:

  _____

  _____

- ☐ Description of the method used to make the dispensary inaccessible to the public:

  _____

APPLICATION FOR NEW PHARMACY

Hospital

Form 1B

APPLICANT INFORMATION

☐ Corporation

Cert. of Incorporation # _____ Incorporation Date _____

Hospital name _____

Address _____ Tel _____

_____ Fax _____

_____ _____ Email _____

Postal code

*Director **	*Pharmacist*	*Director **	*Pharmacist*
_____	☐	_____	☐
_____	☐	_____	☐

* Majority must be BC licensed pharmacists

PROPOSED PHARMACY INFORMATION

Operating name _____

Address _____ Tel _____

_____ Fax _____

_____ _____ Manager _____

Postal code

Contact ✦ _____

Opening date _____ Tel ✦ _____

Software Vendor _____ Fax ✦ _____

✦ *Only if manager not available before opening*

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Application Fee	525.00
Initial License Fee	1,181.25
GST	85.31
Total	**$1,791.56**

GST # R106953920

I attest that:

☐ The Pharmacy is in compliance with the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ I have read and understood the Pharmacy Licensure in British Columbia – Information Guide and Resources package.

_____ _____

Name (please print) Signature

_____ _____

Position Date

APPLICATION FOR NEW PHARMACY

Hospital

APPLICATION REQUIREMENT CHECKLIST

Application must be received by the College Office <u>at least 8 weeks</u> prior to the proposed opening date.

The following must be submitted together with this application:

- ☐ Diagram detailing the layout (see diagram requirement checklist below)
- ☐ Copy of the Certificate of Incorporation
- ☐ Copy of the certified Incorporation Application
- ☐ Copy of the certified Notice of Articles

The following must be submitted at least 2 business days prior to opening:

- ☐ Acknowledgement of Completion of Confidentiality Form

DIAGRAM REQUIREMENT CHECKLIST

The following information must be included on the diagram:

scale: ¼ inch = 1 foot

- ☐ Dispensary area size - minimum 15 m^2 (160 sq. ft.)
- ☐ Dispensary area counters - minimum 3 m^2 (30 sq. ft.)
- ☐ Storeroom space - minimum 4 m^2 (40 sq. ft.) of shelf space
- ☐ Description of the front counter and shelf height
- ☐ Location of the double stainless steel sink
- ☐ Location of the refrigerator
- ☐ Location and type of consultation area (semi-private or private)
- ☐ Drug storage cabinet and/or safe
- ☐ Type of security system
- ☐ Location of Professional Service Area or Schedule 2 items, if applicable
- ☐ Location of Professional Product Area or Schedule 3 items - visible and up to 7.6 m (25 ft) from dispensary, if applicable
- ☐ Location of "Medication Information" sign, if applicable

The following information must be provided:

- ☐ Description of how the professional service area is made visually distinctive or indicate location of Pharmacy signs:

  _____

  _____

- ☐ Description of the method used to make the dispensary inaccessible to the public:

  _____

Form 1C

APPLICATION FOR NEW PHARMACY

Education Site

APPLICANT INFORMATION

☐ Corporation ☐ Sole proprietor / Partnership

Cert. of Incorporation # _____ Incorporation Date _____

Company name _____

Address _____ Tel _____

_____ Fax _____

_____ _____ Email _____

Postal code

PROPOSED PHARMACY INFORMATION

Institution name _____

Address _____ Tel _____

_____ Fax _____

_____ _____ Manager _____

Postal code

Contact ✦ _____

Opening date _____ Tel ✦ _____

Fax ✦ _____

✦ *Only if manager not available before opening*

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Application Fee	525.00
Initial License Fee	315.00
GST	42.00
Total	**$882.00**

GST # R106953920

I attest that:

☐ The Pharmacy is in compliance with the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ I have read and understood the Pharmacy Licensure in British Columbia – Information Guide and Resources package.

_____ _____

Name (please print) Signature

_____ _____

Position Date

APPLICATION FOR TELEPHARMACY SERVICES

Form 2

APPLICANT INFORMATION

Company name _____

Central pharmacy _____

Pharmacy manager _____

Address _____ Tel _____

_____ Fax _____

_____ _____ Email _____

Postal code

PROPOSED REMOTE SITE

Operating name _____

Address _____

_____

_____ _____

Postal code

Tel _____

Fax _____

Email _____

Hours of operation for Telepharmacy _____

_____

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Application Fee	525.00
Licence Fee	210.00
GST	36.75
Total	**$771.75**

GST # R106953920

I attest that:

☐ The Pharmacy is in compliance with the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ I have read and understood the Pharmacy Licensure in British Columbia – Information Guide and Resources package.

_____ _____

Name (please print) Signature

_____ _____

Position Date

APPLICATION FOR TELEPHARMACY SERVICES

APPLICATION REQUIREMENT CHECKLIST

Application must be received by the College Office <u>at least 60 days</u> prior to the planned operation of telepharmacy.

Application must be approved PRIOR to commencement of telepharmacy services.

The following must be submitted together with this application:

- ☐ Diagram detailing the layout of the telepharmacy services at the remote site
- ☐ Copy of final Policy and Procedure Manual which outlines specific telepharmacy operations (see template on College website at www.bcpharmacists.org)

PharmaNet Connection for both sites? ☐ Yes ☐ No

APPLICATION FOR HOSPITAL SATELLITE

Form 3

APPLICANT INFORMATION

Company name _____

Central pharmacy _____

Pharmacy manager _____

Address _____ Tel _____

_____ Fax _____

_____ _____ Email _____

Postal code

PROPOSED REMOTE SITE

Remote Site _____

Name of pharmacy

Address _____

_____

_____ _____

Postal code

Tel _____

Fax _____

Email _____

Hours of operation for Satellite _____

_____

PAYMENT OPTION

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder name _____

Cardholder signature _____

Application Fee	525.00
Licence Fee	210.00
GST	36.75
Total	**$771.75**

GST # R106953920

I attest that:

☐ The Pharmacy is in compliance with the Health Professions Act, the Pharmacy Operations and Drug Scheduling Act, the Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.

☐ I have read and understood the Pharmacy Licensure in British Columbia – Information Guide and Resources package.

_____ _____

Name (please print) Signature

_____ _____

Position Date

APPLICATION FOR HOSPITAL SATELLITE

APPLICATION REQUIREMENT CHECKLIST

Application must be received by the College Office <u>at least 60 days</u> prior to the planned operation of hospital satellite.

Application must be approved PRIOR to commencement of hospital satellite service.

The following must be submitted together with this application:

- ☐ Diagram detailing the layout of the hospital satellite services at the remote site
- ☐ Copy of final Policy and Procedure Manual which outlines specific hospital satellite operations (see template on College website at www.bcpharmacists.org)

PharmaNet Connection for both sites? ☐ Yes ☐ No

FORM 4

COMMUNITY PHARMACY LICENCE RENEWAL NOTICE

Date

Pharmacy Manager

Pharmacy
Address
City, Prov, Postal Code

Dear Pharmacy Manager:

Pharmacy Licensure Expiry:

Enclosed please find your Pharmacy Licence Renewal Notice. Note that all fields of information are mandatory. Terms of a pharmacy licence renewal can be found in the Pharmacy Operations and Drug Scheduling Act (PODSA), section 3.

Pages 1 and 2 must be completed, signed and returned with payment and a copy of the pharmacy's valid business licence. If the College does not receive your completed renewal package **on or before** your licence expiry date, your pharmacy must remain closed until the College confirms reinstatement of your pharmacy licence. Terms of reinstatement of your pharmacy licence can be found in PODSA, section 4. Please note that it is a contravention of the Pharmacy Operations and Drug Scheduling Act to operate an unlicensed pharmacy.

If you are enclosing individual pharmacist registration fees with your remittance, include each individual Pharmacist Registration Renewal Notice so we can track whose fees are covered by the payments.

If you have any questions or comments, please feel free to contact:

Doris Wong
Administrative Assistant – Renewals & Records
(604) 676-4224 or doris.wong@bcpharmacists.org

Yours truly,

Registrar

COMMUNITY PHARMACY LICENCE RENEWAL NOTICE

ID #	
Pharmacare #	
Current licence expires	

PHARMACY

Pharmacy Manager
Pharmacy
Address
City, Prov Postal Code

Tel: *
Fax: *
Email: *

* *required information - please provide update*

OWNER

Name of Owner
(Corporation or Sole Proprietor)

Corporate Director(s)

Has there been a change of directors? If yes, a copy of Notice of Articles / Notice of Directors must be provided.

PAYMENT ADVICE

	FEE	GST	TOTAL	
Pharmacy licence fee	$1,181.25	+ $ 59.06 =	**$1,240.31**	**$1,240.31**

Pharmacist registration (optional)

Full Pharmacist registration fee	$630.00	+$31.50 =	**$661.50**	X _____ =	$ _____
Full Pharmacist registration fee with building assessment	$682.50	+ $34.13 =	**$716.63**	X _____ =	$ _____
Non-Practising Pharmacist registration fee	$504.00	+ $25.20 =	**$529.20**	X _____ =	$ _____

Payment option

Total payment $

- ☐ Cheque/Money order *(payable to College of Pharmacists of BC)*
- ☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder _____

Cardholder signature _____

GST # R106953920

Please return this notice with payment

over >>>

COMMUNITY PHARMACY LICENCE RENEWAL NOTICE

ID #	
Pharmacare #	
Current licence expires	

STAFF PHARMACISTS

Confirm if the following are still employed at this pharmacy by checking one of the checkboxes

Current employee?	Name	Reg #	Status	Renewed To
☐ Yes ☐ No				
☐ Yes ☐ No				

Add Pharmacists not listed above in the following table. Attach additional sheet if necessary

Name	Reg #	Full time	Part time	Casual

☐ I attest that:

- The Pharmacy is in compliance with the Health Professions Act (HPA), the Pharmacy Operations and Drug Scheduling Act (PODSA), the Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.
- I understand my obligations as described in Part I of the PODSA bylaws: "Responsibilities of the Pharmacy Managers, Owners and Directors."

☐ I attach a copy of the pharmacy's valid business licence.

Date (Pharmacy Manager)

HOSPITAL PHARMACY LICENCE RENEWAL

Date

Pharmacy Manager
Pharmacy
Address
City Prov Postal Code

Dear Pharmacy Manager,

Pharmacy Licensure Expiry:

Enclosed please find your Pharmacy Licence Renewal Notice. Note that all fields of information are mandatory. Terms of a pharmacy licence renewal can be found in the Pharmacy Operations and Drug Scheduling Act (PODSA), section 3.

Pages 1 and 2 must be completed, signed and returned with payment. If the College does not receive your completed renewal package **on or before** your licence expiry date, your pharmacy must remain closed until the College confirms reinstatement of your pharmacy licence. Terms of reinstatement of your pharmacy licence can be found in PODSA, section 4. Please note that it is a contravention of the Pharmacy Operations and Drug Scheduling Act to operate an unlicensed pharmacy.

If you are enclosing individual pharmacist registration fees with your remittance, include each individual Pharmacist Registration Renewal Notice so we can track whose fees are covered by the payments.

If you have any questions or comments, please feel free to contact:

Doris Wong
Administrative Assistant – Renewals & Records
(604) 676-4224 or doris.wong@bcpharmacists.org

Yours truly,

Registrar

HOSPITAL PHARMACY LICENCE RENEWAL NOTICE

ID #	
Pharmacare #	
Current licence expires	

PHARMACY

(Pharmacy Manager)
PHARMACY
Address
City, Prov
Postal Code

Tel: *
Fax: *
Email: *

* *required information - please provide update*

HEALTH AUTHORITY

Name of Health Authority

PAYMENT ADVICE

	FEE	GST	TOTAL	
Pharmacy licence fee	$1,181.25	+$ 59.06	=**$1,240.31**	**$ 1,240.31**

Pharmacist registration (optional)

Full Pharmacist registration fee	$630.00	+ $31.50	= **$661.50**	X ____	= $ ____
Full Pharmacist registration fee with building assessment	$682.50	+ $34.13	= **$716.63**	X ____	= $ ____
Non-Practising Pharmacist registration fee	$504.00	+ $ 25.20	= **$529.20**	X ____	= $ ____

Payment option

Total payment $

☐ Cheque/Money order *(payable to College of Pharmacists of BC)*

☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder _____

Cardholder signature _____

GST # R106953920

Please return this notice with payment

over >>>

HOSPITAL PHARMACY LICENCE RENEWAL NOTICE

ID #	
Pharmacare #	
Current licence expires	

STAFF PHARMACISTS

Name	Reg #	Status	Renewed To	Name	Reg #	Status	Renewed To

Add Pharmacists not listed above in the following table. Attach additional sheet if necessary

Name	Reg #	Full time	Part time	Casual

☐ I attest that:

- The Pharmacy is in compliance with the Health Professions Act (HPA), the Pharmacy Operations and Drug Scheduling Act (PODSA), the Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.
- I understand my obligations as described in Part I of the PODSA bylaws: "Responsibilities of the Pharmacy Managers, Owners and Directors."

Date (Pharmacy Manager)

EDUCATION SITE LICENCE RENEWAL

Date

Pharmacy Manager
Pharmacy
Address
City, Prov Postal Code

Dear Pharmacy Manager,

Education Site Licensure Expiry:

Enclosed please find your Education Site Licence Renewal Notice. Note that all fields of information are mandatory. Terms of an Education Site licence renewal can be found in the Bylaws of the Pharmacy Operations and Drug Scheduling Act (PODSA), section 5.

Pages 1 and 2 must be completed, signed and returned with payment on or before your licence expiry date.

If you are enclosing individual pharmacist registration fees with your remittance, include each individual Pharmacist Registration Renewal Notice so we can track whose fees are covered by the payments.

If you have any questions or comments, please feel free to contact:

Doris Wong
Administrative Assistant – Renewals & Records
(604) 676-4224 or doris.wong@bcpharmacists.org

Yours truly,

Registrar

EDUCATION SITE LICENCE RENEWAL NOTICE

ID #	
Pharmacare #	
Current licence expires	

PHARMACY

Pharmacy Manager
Pharmacy
Address
City, Prov Postal Code

Tel: *
Fax: *
Email: *

* *required information - please provide update*

SITE OWNER

Name of Site Owner

PAYMENT ADVICE

	FEE	GST	TOTAL	
Pharmacy licence fee	$315.00	+ $15.75 =	**$330.75**	**$330.75**

Pharmacist registration (optional)

Full Pharmacist registration fee	$630.00 + $ 31.50 =	$661.50	X ____ = $	____
Full Pharmacist registration fee with building assessment	$682.50 + $34.13 =	$716.63	X ____ = $	____
Non-Practising Pharmacist registration fee	$504.00 + $25.20 =	$529.20	X ____ = $	____

Payment option

Total payment $

- ☐ Cheque/Money order *(payable to College of Pharmacists of BC)*
- ☐ VISA ☐ MasterCard

Card # _____ Exp ____/____

Cardholder _____

Cardholder signature _____

GST # R106953920

H0034-10212009

Please return this notice with payment

over >>>

EDUCATION SITE LICENCE RENEWAL NOTICE

ID #	
Pharmacare #	
Current licence expires	

STAFF PHARMACISTS

Name	Reg #	Status	Renewed To	Name	Reg #	Status	Renewed ToBB

Add Pharmacists not listed above in the following table. Attach additional sheet if necessary

Name	Reg #	Full time	Part time	Casual

☐ I attest that:

- The Pharmacy is in compliance with the Health Professions Act (HPA), the Pharmacy Operations and Drug Scheduling Act (PODSA), the Regulation and the Bylaws of the College of Pharmacists of British Columbia made pursuant to these Acts.
- I understand my obligations as described in Part I of the PODSA bylaws: "Responsibilities of the Pharmacy Managers, Owners and Directors."

Date (Pharmacy Manager)

College of Pharmacists of British Columbia | 200 - 1765 West 8th Ave, Vancouver, BC V6J 5C6 | Tel: 604.733.2440 | Fax: 604.733.2493 | www.bcpharmacists.org