College of Pharmacists
of British Columbia

APPLICATION FOR CHANGE OF INDIRECT OWNER(S)

PODSA Form 8B

1. CURRENT PHARMACY INFORMATION

Operating Name	External Signage Name	Pharmacy Licence Number	
Pharmacy Address	**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	
Manager Name		**Manager's Registration Number (BC)**	

2. DEPARTING INDIRECT OWNER(S)

Type	Company/Corporation Name	Name of Indirect Owner	Pharmacist (Y/N)	Effective Date of Change
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder			☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY

*If known

3. NEW INDIRECT OWNER(S)

Type	Company/Corporation Name	Name of Indirect Owner	Pharmacist (Y/N)	Effective Date of Change
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY
☐ Director ☐ Officer ☐ Shareholder		**Name:** **Email:**	☐ Y – Registration #: _______ ☐ N – eServices ID*: _______	MMM | DD | YYYY

*If known

4. ADDITIONAL INFORMATION

As a result of this change (indirect owner):

a)	Will the **pharmacy operating name** or **external signage name** be changed at the same time?	☐ Yes – Complete **Form 8E**	☐ No
b)	Will the **pharmacy layout** be changed at the same time?	☐ Yes – Complete **Form 8G**	☐ No
c)	Will any **other pharmacies** be affected by this change of indirect owner?	☐ Yes – Complete **Form 9**	☐ No

5. APPLICANT (DIRECT OWNER) INFORMATION

Name of Authorized Representative	**Position/Title of Authorized Representative**	
Email Address	**Phone Number**	**Fax Number**
Signature	**Date** MMM | DD | YYYY	

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