



Newfoundland & Labrador Pharmacy Board

Suite 201 – 145 Kelsey Drive
St. John's, NL, A1B 0L2
Website www.nlpb.ca

Telephone (709) 753-5877 or 1-877-453-5877 (toll free)
Fax (709) 753-8615
e-mail registration@nlpb.ca

Application for Registration as a Pharmacist in Newfoundland and Labrador

Demographic Information:

_____	_____	_____
Last Name	First Name & Middle Initial	
_____	_____	_____
Maiden Name (if applicable)	Date of Birth (DD/MM/YYYY)	Gender

Contact Information:

_____	_____
Email Address	Phone Number

Mailing Address:

_____	_____
Street Address (or P.O. Box)	City/Town
_____	_____
Province	Postal Code

Academic Information:

_____	_____	_____	_____
Initial Pharmacy Degree Earned	University/College Attended	Province/Country	Graduation Date
_____	_____	_____	_____
Additional Pharmacy Degree Earned	University/College Attended	Province/Country	Graduation Date

Pharmacy Examining Board of Canada Qualifying Exam Status:

_____	_____
Date Completed (DD/MM/YYYY)	Registration #

Have you ever been found guilty or convicted of an offence under any provincial or federal statute in Canada or another country? (If "Yes," please attach details)

Yes No

Are you the subject of a current proceeding relating to an offence under any provincial or federal statute in Canada or another country? (If "Yes," please attach details)

Yes No

If you **ARE CURRENTLY, OR WERE PREVIOUSLY**, registered as a pharmacist in another jurisdiction, please provide details below:

Jurisdiction	Registration #	Registration Expiry Date	Category of Registration
Is your registration <u>currently</u> restricted, suspended or revoked in any other jurisdiction? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", please attach details)			
Has your registration <u>ever been</u> restricted, suspended, or revoked in any other jurisdiction? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please attach all pertinent details)			
If "Yes", are you currently eligible to practice pharmacy in that jurisdiction? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Please provide details regarding where you will be practicing in NL:

Category: Administrative Community Hospital Relief

Pharmacy/Employer Name: _____

Full Mailing Address: _____

Anticipated # hours per week: _____

By signing below, I certify that:

- The information contained in this application is complete and correct and I recognize that providing false or incomplete information on this application may be cause for revocation of registration.
- I will provide the Registrar with the details of any of the following that occur or arise after my registration:
 - A charge relating to an offence under any provincial or federal statute in Canada or another country.
 - A finding of guilt or conviction in relation to an offence under any provincial or federal statute in Canada or another country.
- I will abide by the requirements of the Pharmacy Act, its Regulations, Bylaws and Standards of Practice established by the Newfoundland and Labrador Pharmacy Board.
- I have read the NLPB *Policy on Collection, Use and Disclosure of Registrants' Information* and confirm that I consent to the release of personal information in accordance with this policy.
- I have provided:
 - A copy of my current professional liability insurance coverage certificate in accordance with the NLPB Policy, *Professional Liability Insurance Requirements for Registration*. I understand that I am responsible for ensuring that this coverage is maintained throughout the year.
 - An original, current certificate of conduct (issued within the past six months) from the Royal Newfoundland Constabulary, the Royal Canadian Mounted Police or other appropriate policing agency.
 - Verification of English Language Proficiency, in accordance with the NLPB Policy, *English Language Proficiency Requirements for Registration (only applicable to international pharmacy graduates)*.
 - An official transcript or original diploma indicating graduation from a CCAPP-accredited pharmacy program.
 - Proof of membership in the Pharmacists' Association of Newfoundland and Labrador. I understand that I am responsible for ensuring that this membership is maintained throughout the year.
 - Copy of government-issued photo identification.
- I have included payment information for the current Pharmacist Registration fee, as indicated in the NLPB *Schedule of Fees*.

Applicant Signature

Date Signed

Fee Paid By: Cheque or Money Order VISA Mastercard

Please Print Full Name on Card: _____

Card #

Expiry Date

CVV # (on back of card)