



# Newfoundland & Labrador Pharmacy Board

Suite 201 – 145 Kelsey Drive  
St. John's, NL A1B 0L2  
Website [www.nlpb.ca](http://www.nlpb.ca)

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## Application for Satellite Pharmacy Services

*(in accordance with the NLPB Licensing Requirements for Satellite Pharmacies in Rural Communities Without Conventional Pharmacy Service)*

### Primary Pharmacy Information:

\_\_\_\_\_  
Pharmacy Licence #

\_\_\_\_\_  
Pharmacy Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
P.O. Box (if applicable)

\_\_\_\_\_  
City/Town

\_\_\_\_\_  
Postal Code

( ) \_\_\_\_\_  
Phone Number

( ) \_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Pharmacy Email Address

\_\_\_\_\_  
Name of Pharmacist-in-Charge

\_\_\_\_\_  
Pharmacist-in-Charge Registration #

### Satellite Pharmacy Information:

\_\_\_\_\_  
Operating Name of Satellite Pharmacy

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
P.O. Box (if applicable)

\_\_\_\_\_  
City/Town

\_\_\_\_\_  
Postal Code

( ) \_\_\_\_\_  
Phone Number

( ) \_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Pharmacy Email Address

#### Hours of Operation:

**Monday-Friday:** \_\_\_\_\_

**Saturday:** \_\_\_\_\_

**Sunday:** \_\_\_\_\_

**Holidays:** \_\_\_\_\_

\_\_\_\_\_  
Anticipated Opening Date

\_\_\_\_\_  
Proposed Site Visit Date

**Certifications:**

- I certify that the information provided on this application is correct and make application to open the satellite pharmacy as indicated above, in accordance with the *NLPB Licensing Requirements for Satellite Pharmacies in Rural Communities Without Conventional Pharmacy Service*. I understand that should any of this information change, I must complete and submit an updated copy of this form.
- I have enclosed a detailed diagram of the layout of the satellite pharmacy with this application or a diagram will follow with the understanding that the application will not be approved until it is received by the NLPB Office. I understand that I may also be required to provide supporting photographs.
- I have enclosed the appropriate fee, as indicated in the NLPB Schedule of Fees.

\_\_\_\_\_  
Pharmacist-in-Charge Signature

\_\_\_\_\_  
Date Signed

**Fee Paid By:**     Cash, Cheque or Money Order     VISA     Mastercard

\_\_\_\_\_  
Name on Card

\_\_\_\_\_  
Card #

\_\_\_\_\_  
Expiry Date

**Pharmacists-in-Charge are reminded that the NLPB Office must be notified of any changes related to the information provided on this application, including renovation, relocation or closure of the satellite pharmacy.**