Nova Scotia College of Pharmacists

APPENDIX B

Notification Form: Intent to Utilize Centralized Prescription Processing between pharmacies within Nova Scotia ONLY

Notification Date: _____

Originating Pharmacy	
Pharmacy Name:	Pharmacy Licence Number:
Pharmacy Address:	
Pharmacy Email:	
Name of Pharmacy Manager:	License Number:
Pharmacy Manager Email:	
Pharmacy Phone:	Pharmacy Fax:
Pharmacy Owner or Pharmacy Owner's Representative*:	
Pharmacy Owner or Representative Email:	
Centralized Processing Pharmacy	
Pharmacy Name:	Pharmacy Licence Number:
Pharmacy Address:	
Pharmacy Email:	
Name of Pharmacy Manager	License Number:
Pharmacy Manager Email:	
Pharmacy Phone:	Pharmacy Fax:
Pharmacy Owner or Pharmacy Owner's Representative*:	
Pharmacy Owner or Representative Email:	

Pharmacy Owner or Pharmacy Owner's Representative

*PLEASE NOTE: The Pharmacy Owner's Representative is not necessarily the Pharmacy Manager. The Pharmacy Owner's Representative is an individual with authority to bind the owner in undertakings provided to the College with respect to the pharmacy, including the certification of compliance required by clause 23(1)(a) of the Pharmacy Act before a licence is issued. (Registration, Licensing and Professional Accountability Regulations s.25(2)).

The pharmacist in charge of a pharmacy (i.e., on duty at a given time), the owner of a pharmacy, the manager of a pharmacy, and every director of a corporation that owns a pharmacy, are responsible for compliance with the Pharmacy Act and the regulations.

I hereby certify that the statements set out in this Application are true and correct and further that I have read the NSCP's *Centralized Prescription Processing (Central Fill)* policy and that I have complied, and will continue to comply, with it.

Originating Pharmacy: Owner or Pharmacy Owner's Representative Signature: _____Date:_____	Central Fill Pharmacy: Owner or Pharmacy Owner's Representative Signature: _____Date:_____
Originating Pharmacy: Pharmacy Manager's Signature: _____Date:_____	Central Fill Pharmacy: Pharmacy Manager's Signature: _____Date:_____

Please submit this form via email to: centralfill@nspharmacists.ca