Nova Scotia Pharmacy Regulator

Notification of Intent to Provide Direct Patient Care Not Under the Jurisdiction of a Pharmacy

Date of Notification (DD/MM/YY)	
Proposed Start Date of Services (DD/MM/YY)	

Practice Location		
Address:		
City:	Province:	Postal Code:

Registrant Providing Direct Patient Care	
Name:	Licence Number:
Address:	Email Address:

Business Under Which the Services Will Be Provided (if applicable)	
Business Name:	
Business Address:	
Owner Name:	NSPR Licence Number (if applicable):
Phone:	Fax (if applicable):
Email Address:	

Pharmacy Services
Please provide a description of the pharmacy services to be provided.

Acknowledgment	
☐	I understand that my practice as a direct patient care pharmacist is subject to the Regulated Health Professions Act, associated regulations, bylaws, code of ethics, standards of practice, practice policies, and positions.

Declarations	
Please read and agree to the following declarations:	
☐	I declare that I will not provide services that are only authorized to be provided in pharmacy, including the dispensing and compounding of drugs.
☐	I understand that I must maintain appropriate security and protections to ensure the confidentiality of all records and patient information.
☐	I declare that all patient records will be kept as set out in the Pharmacy Legislation, bylaws, and standards of practice.
☐	I understand that I must maintain a continuity plan to ensure the preservation of patient records and the orderly continuation of patient care should an event, including an unplanned event, occur that precludes me from continuing to provide this service.
☐	I understand that all premises and records maintained by a pharmacist with respect to the provision of pharmacy services outside the premises of a licensed pharmacy are subject to audit and custodianship by the NSPR as set out in the Pharmacy Regulations, bylaws and standards of practice.
☐	I understand that I must advise the NSPR if I cease to provide this service at this location or if I cease to be associated with this service or this business.
☐	I understand that, should I cease to provide this service or to be associated with this service or this business, I must ensure that: • all patients are notified; • steps are taken to preserve patient records and, where applicable, transfer patient records; and • steps are taken to provide for the orderly continuation of patient care.
☐	I understand that I must provide this notification along with the associated fee on an annual basis, on or before December 31.
☐	I understand that I must notify the NSPR if any of the information provided in this notification changes.
Name:	Licence Number:
Signature*:	Date:

Payment Options: Please see the Schedule of Fees
Visa, Visa Debit, Mastercard or Debit Mastercard (payment link to be sent by email)

* I understand that typing my name in this field constitutes a legal signature.

clear form

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