



Application for Certificate of Accreditation as a Pharmacy

(Check all that apply)

Fee (incl. HST)

See page 5 for payment information

<input type="checkbox"/> New Pharmacy Opening (complete Section A, B, C & D and submit Floor Plan)	\$1130	<input type="checkbox"/> The pharmacy will operate a Remote Dispensing Location (Complete Section G)	\$565	<input type="checkbox"/> The pharmacy will operate a Lock and Leave (Complete Section H)	—
<input type="checkbox"/> Purchase of Existing Pharmacy or Amalgamation (complete Section A, B, C, D & E)	\$565	<input type="checkbox"/> The pharmacy will operate a NEW Remote Dispensing Location (Complete Section G)	\$1130	<input type="checkbox"/> The pharmacy will operate a NEW Lock and Leave (Complete Section H)	\$282.50
<input type="checkbox"/> Relocation of Existing Pharmacy (complete Section A, B, C, D, F & submit Floor Plan)	\$565	<input type="checkbox"/> The pharmacy will operate a NEW Remote Dispensing Location (Complete Section G)	\$1130	<input type="checkbox"/> The pharmacy will operate a NEW Lock and Leave (Complete Section H)	\$282.50
<input type="checkbox"/> Existing Pharmacy to operate a Remote Dispensing Location (complete Section A & G)	\$1130				
<input type="checkbox"/> Existing Pharmacy to operate a Lock and Leave (complete Section A & H)	\$282.50				

Primary Contact Person for Application Processing

Name:

Telephone:

Email:

.....

Pharmacy Information

Owner of Pharmacy/Corporation Name:

Accreditation Number: (if existing)

Trading Name of Pharmacy: (Name by which the pharmacy is known to the public)

A

Address of Pharmacy:

City/Town:

Province:

Postal Code:

.....

Proposed Date of Opening:

Pharmacy Hours of Operation:

Usual & Customary Fee:

Telephone Number:

Fax Number:

Email Address:

Website:

B

Description of Pharmacy: Plaza/Mall Medical Clinic Freestanding Other:

Specialty Services:

Methadone Specialty Compounding Sterile IV Prep Long Term Care/Nursing Home

Group/Retirement Home Mail Order Other:

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Corporation Information

For corporations which have never owned or operated a pharmacy in Ontario, **Articles of Incorporation or Amending Articles** and **Share Certificates** must be submitted with this application.

DIRECTOR(S) OF THE PHARMACY/CORPORATION

(1) Name:	OCP Number:
.....
(2) Name:	OCP Number:
.....
(3) Name:	OCP Number:
.....

SHAREHOLDERS

(1) Name:	OCP Number:
.....
Address:	% of Shares:
.....
(2) Name:	OCP Number:
.....
Address:	% of Shares:
.....
(3) Name:	OCP Number:
.....
Address:	% of Shares:
.....

DIRECTOR LIAISON

Name:	OCP Number:
.....
Email Address:	Telephone:
.....
Signature of Director Liaison:	Date:
.....



Pharmacy Personnel

DESIGNATED MANAGER

Name:

OCP Number:

.....
Email Address: (required)

.....
Signature of Designated Manager:

.....
Date:

NARCOTIC SIGNERS

(1) Name:

OCP Number:

.....
(2) Name:

.....
OCP Number:

.....
(3) Name:

.....
OCP Number:

D

PHARMACISTS *(without Narcotic Signing Authority)*

(1) Name:

OCP Number:

.....
(2) Name:

.....
OCP Number:

.....
(3) Name:

.....
OCP Number:

PHARMACY TECHNICIANS

(1) Name:

OCP Number:

.....
(2) Name:

.....
OCP Number:

.....
(3) Name:

.....
OCP Number:

Purchase of an Existing Pharmacy – Purchaser/Seller Agreement

Name of Purchaser:

OCP Number:

Signature: (required)

E

.....
Name of Seller:

.....
OCP Number:

.....
Signature: (required)



Relocation of an Existing Pharmacy – New Pharmacy Address

New Address of Pharmacy:

.....
City/Town: Province: Postal Code:

.....
Telephone Number: Fax Number: Email Address: Proposed Date of Opening:

F
Pharmacy Hours of Operation: Website:

.....
Description of Pharmacy: Plaza/Mall Medical Clinic Freestanding Other:

.....
Specialty Services: Methadone Specialty Compounding Sterile IV Prep Long Term Care/Nursing Home
 Group/Retirement Home Mail Order Other:

Application to Operate a Remote Dispensing Location

Address of Remote Dispensing Location:

.....
City/Town: Province: Postal Code:

.....
Description of Location: Proposed Opening Date:

.....
Does RD Location contain an Automated Pharmacy System? Yes No

G If yes, please describe the technology:
.....
.....

Is the RD Location a Dispensary? Yes No

If yes, please provide Pharmacy Technician information:

(1) Name of Pharmacy Technician: OCP Number:
.....

(2) Name of Pharmacy Technician: OCP Number:
.....

Signature of Director Liaison: Date:
.....



Application to Operate a Lock & Leave

Please provide details about the fixtures used, including supporting documents such as floor plans, dimensions, pictures, etc. in order to demonstrate restricted public access.

H

Signature of Director Liaison:

Date:

PAYMENT INFORMATION

I wish to pay by Credit Card

Amount:

Credit Card Number:

Expiry Date:

Visa

Mastercard

American Express

Cardholder's Name: (as it appears on credit card)

Cardholder Signature:

Date:

Telephone:

I am enclosing a cheque

Payable to Ontario College of Pharmacists in the amount of:

Amount:

Send completed forms to: Ontario College of Pharmacists, 483 Huron St, Toronto, ON M5R 2R4
or by fax to 416-847-8200 (Attention: Client Services) or scan and email to: ocpclientservices@ocpinfo.com