



**APPLICATION FOR REGISTRATION AS A PHARMACIST**  
(for applicants who are currently licensed in another Canadian jurisdiction)

| Applicant Information (please print)                             |          |  |               |
|--|----------|--|---------------|
| Date   |          |  |               |
| Surname  |          | Maiden Name                                      |               |
| First Name   |          | Second Name                                      |               |
| Street Address   |          | Apt. #   | Email Address |
| City   | Province | Postal Code                                      | Phone (Home)  |
| Business Name and Address  |          |  |               |
| University Name  |          | Graduation Date                                  |               |
| Post Graduate Pharmacy Degrees                                   |          | Province of Current Registration                 |               |
| Date of Initial Registration as a Pharmacist                     |          | Province of Initial Registration as a Pharmacist |               |
| Have you ever been licensed to practice pharmacy in Nova Scotia? |          | If so, when?                                     |               |
| PEBC Qualification Number  |          | PEBC Date  |               |
| Field of Practice (Community, Hospital, Other)                   |          | Mail Preference (home or work)                   |               |

| Required Documents and fees (please enclose)   | For Office Use Only |
|--|---------------------|
| 1. Proof of Professional liability insurance coverage as approved by NSCP  |                     |
| 2. Copy of either a birth or Canadian Citizenship certificate (photocopy both sides of documents).<br>(Landed Immigrant and/or Baptismal Certificates are not acceptable).<br><br>Birthdate: _____   |                     |
| 3. Statement of disclosure regarding any previous criminal convictions, disciplinary convictions or civil remedies relating to the practice of pharmacy obtained against the applicant; or any conditions placed on current license to practice pharmacy by any regulatory authority.  |                     |
| 4. Original copy of a criminal record check (conducted within the 3 months preceding this application)   |                     |
| 5. Letter of Standing from applicant's current regulatory authority including the classification of license to practice, any conditions currently associated with the applicant's license to practice and confirmation that there are no outstanding complaints against the applicant. |                     |
| 6. Declaration by applicant that he/she has/has not fulfilled the Continuing Education/Continuing Competence/Quality Assurance requirements for licensure in the province of current registration.   |                     |
| 7. Registration Fee  |                     |

**Payment Options**☐ Debit, Visa, or MasterCard (In Person Only)☐ Cheque (cheques payable to: Nova Scotia College of Pharmacists)

I understand that in order to practice pharmacy in Nova Scotia I must read and understand the legislation and regulations governing the practice of pharmacy in Nova Scotia and I agree to comply with the provisions found therein.

I confirm that I am aware of my professional and ethical responsibilities as set out in the *Pharmacy Act*, Regulations, Code of Ethics and Standards of Practice.

I confirm that I have obtained professional liability insurance in accordance with the Regulations under the Pharmacy Act and that I am responsible for ensuring that this coverage is maintained throughout the licensing year. I acknowledge that the license issued to me is dependent upon the fulfillment of this obligation.

I understand that the NSCP will disclose, in compliance with PIPEDA and in accordance with a data sharing agreement, registration information in a de-identified format to the Canadian Institute of Health Information (CIHI) for the purposes of the maintenance of a national pharmacist database primarily for use in workforce planning.

I understand that the NSCP will disclose, in compliance with PIPEDA and in accordance with a data sharing agreement, identifying registration information to the NS provincial government's SHARE initiative. SHARE (Secure Health Access Record), Nova Scotia's Electronic Health Record, requires identifying information specific to health care providers including physicians, nurses and pharmacists to enable the unique identification of providers associated with the EHR.

I agree to notify the Nova Scotia College of Pharmacists of any changes in the "Applicant Information" section of this application form.

**All applicants must present this application form IN PERSON to the NSCP office.** Supporting documents may be provided separately.

**Applicant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PLEASE ALLOW 2-3 BUSINESS DAYS FOR PROCESSING**

**Office Use Only**

**I HEREBY VERIFY** that the person presenting this application is the person whose name appears as an Applicant, and whose identity has been proven to my satisfaction through presentation of identification and who signed this document in my presence this

\_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.

NSCP Witness Signature: \_\_\_\_\_

Date received: \_\_\_\_\_ Registration #: \_\_\_\_\_

Fee included: \_\_\_\_\_ Receipt #: \_\_\_\_\_

## CIHI Data Collection Form

### SECTION TWO: STATISTICAL INFORMATION

This section is to be completed by **PRACTICING PHARMACISTS** only

#### Box D: Residence

Full Name \_\_\_\_\_ Registration/ License No. \_\_\_\_\_

Province of Current Residence \_\_\_\_\_ Province of Registration \_\_\_\_\_

NS

#### Box E: Educational Background

##### Initial Pharmacy Degree

- ☐ Diploma University \_\_\_\_\_
- ☐ Baccalaureate Country of University \_\_\_\_\_
- ☐ Master's Initial Graduation Year \_\_\_\_\_
- ☐ Pharm D

##### Additional Pharmacy degree (highest level only)

- ☐ Baccalaureate University \_\_\_\_\_
- ☐ Masters Country of University \_\_\_\_\_
- ☐ Pharm D Year Earned \_\_\_\_\_
- ☐ Doctorate
- ☐ Accredited Residency

#### Box F: Employment Status

- ☐ Employed in the profession of pharmacy ☐ Employed in other than pharmacy and seeking employment in pharmacy
- ☐ Employed in other than pharmacy and **not** seeking employment in pharmacy ☐ Unemployed and seeking employment in pharmacy
- ☐ Unemployed and seeking **not** employment in pharmacy

If you have chosen **Employed in the profession of pharmacy**, you must complete Box **G** below. Complete Boxes **H & I** only if applicable.  
If you have chosen any other option above, you are not required to complete the remainder of this section.

#### Box G: Primary Place of Employment – Complete for your primary place of employment in the profession of pharmacy.

If in Canada, please indicate Province / Territory \_\_\_\_\_ and Postal Code \_\_\_\_\_

If not in Canada, please indicate Country of employment \_\_\_\_\_

##### Area of Employment (Choose only one)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Community Pharmacy                  | <input type="checkbox"/> Other Pharmacy                            | <input type="checkbox"/> Health Related Industry / Mfg/ Commercial   |
| <input type="checkbox"/> Hospital/ Health Care Facility      | <input type="checkbox"/> Other Community Based Pharmacist Practice | <input type="checkbox"/> Association/ Government/ Para- Governmental |
| <input type="checkbox"/> Community Health Care               | <input type="checkbox"/> Community Pharmacy Corporate Office       | <input type="checkbox"/> Other place of work – not Identified        |
| <input type="checkbox"/> Group Professional Practice/ Clinic | <input type="checkbox"/> Post Secondary Educational Institution    |  |

##### Category (Choose only one)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Permanent Employee | <input type="checkbox"/> Temporary Employee | <input type="checkbox"/> Casual Employee |
| <input type="checkbox"/> Self - Employed    |   |  |

##### Primary Position (Choose only one)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Staff Pharmacist | <input type="checkbox"/> Director of Pharmacy              | <input type="checkbox"/> Pharmacist Consultant |
| <input type="checkbox"/> Pharmacy Manager | <input type="checkbox"/> Institutional Leader/ Coordinator | <input type="checkbox"/> Industrial Pharmacist |
| <input type="checkbox"/> Pharmacy Owner   | <input type="checkbox"/> Educator                          | <input type="checkbox"/> Research              |
|   |  | <input type="checkbox"/> Other                 |

**Estimated Hours Per Week:** ☐ 40+ ☐ 30-39 ☐ 15-29 ☐ 14 or less

## CIHI Data Collection Form

### Box H: Secondary Place of Employment – complete **only** if you have a secondary place of employment in the profession of pharmacy.

If in Canada, please indicate Province / Territory \_\_\_\_\_ and Postal Code \_\_\_\_\_

If not in Canada, please indicate Country of employment \_\_\_\_\_

#### Area of Employment (Choose only one)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Community Pharmacy                  | <input type="checkbox"/> Other Pharmacy                            | <input type="checkbox"/> Health Related Industry / Mfg/ Commercial   |
| <input type="checkbox"/> Hospital/ Health Care Facility      | <input type="checkbox"/> Other Community Based Pharmacist Practice | <input type="checkbox"/> Association/ Government/ Para- Governmental |
| <input type="checkbox"/> Community Health Care               | <input type="checkbox"/> Community Pharmacy Corporate Office       | <input type="checkbox"/> Other place of work – not Identified        |
| <input type="checkbox"/> Group Professional Practice/ Clinic | <input type="checkbox"/> Post Secondary Educational Institution    |  |

#### Category (Choose only one)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Permanent Employee | <input type="checkbox"/> Temporary Employee | <input type="checkbox"/> Casual Employee |
| <input type="checkbox"/> Self - Employed    |   |  |

#### Primary Position (Choose only one)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Staff Pharmacist | <input type="checkbox"/> Director of Pharmacy              | <input type="checkbox"/> Pharmacist Consultant |
| <input type="checkbox"/> Pharmacy Manager | <input type="checkbox"/> Institutional Leader/ Coordinator | <input type="checkbox"/> Industrial Pharmacist |
| <input type="checkbox"/> Pharmacy Owner   | <input type="checkbox"/> Educator                          | <input type="checkbox"/> Research              |
|   |  | <input type="checkbox"/> Other                 |

**Estimated Hours Per Week:**      ☐ 40+      ☐ 30-39      ☐ 15-29      ☐ 14 or less

### Box I: Third Place of Employment – complete **only** if you have a third place of employment in the profession of pharmacy.

If in Canada, please indicate Province / Territory \_\_\_\_\_ and Postal Code \_\_\_\_\_

If not in Canada, please indicate Country of employment \_\_\_\_\_

#### Area of Employment (Choose only one)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Community Pharmacy                  | <input type="checkbox"/> Other Pharmacy                            | <input type="checkbox"/> Health Related Industry / Mfg/ Commercial   |
| <input type="checkbox"/> Hospital/ Health Care Facility      | <input type="checkbox"/> Other Community Based Pharmacist Practice | <input type="checkbox"/> Association/ Government/ Para- Governmental |
| <input type="checkbox"/> Community Health Care               | <input type="checkbox"/> Community Pharmacy Corporate Office       | <input type="checkbox"/> Other place of work – not Identified        |
| <input type="checkbox"/> Group Professional Practice/ Clinic | <input type="checkbox"/> Post Secondary Educational Institution    |  |

#### Category (Choose only one)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Permanent Employee | <input type="checkbox"/> Temporary Employee | <input type="checkbox"/> Casual Employee |
| <input type="checkbox"/> Self - Employed    |   |  |

#### Primary Position (Choose only one)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Staff Pharmacist | <input type="checkbox"/> Director of Pharmacy              | <input type="checkbox"/> Pharmacist Consultant |
| <input type="checkbox"/> Pharmacy Manager | <input type="checkbox"/> Institutional Leader/ Coordinator | <input type="checkbox"/> Industrial Pharmacist |
| <input type="checkbox"/> Pharmacy Owner   | <input type="checkbox"/> Educator                          | <input type="checkbox"/> Research              |
|   |  | <input type="checkbox"/> Other                 |

**Estimated Hours Per Week:**      ☐ 40+      ☐ 30-39      ☐ 15-29      ☐ 14 or less