PHARMACIST REGISTRATION FORM

PO Box 2200, Halifax NS B3J 3C6
T 902.496.7123 **TF** 1-877-476-7767
F 902.481.3157
www.nspmp.ca

SECTION A – CONTACT INFORMATION

SURNAME:	FIRST NAME:	MIDDLE NAME:
DATE OF BIRTH: ____/____/______ DD / MM / YYYYY	COUNTRY OF BIRTH:	GENDER (PLEASE CIRCLE): MALE FEMALE

MAILING ADDRESS (CORRESPONDENCE WILL BE SENT TO THIS ADDRESS):

ADDRESS LINE 1:

ADDRESS LINE 2:

CITY/TOWN:	PROVINCE:
POSTAL CODE:	
CONTACT TELEPHONE:	FAX NUMBER:
EMAIL (OPTIONAL):	

SECTION B – EDUCATION AND LICENSING INFORMATION

ORIGINAL PHARMACY DEGREE

GRANTING UNIVERSITY:	COUNTRY:	GRADUATION YEAR:

PROVINCIAL LICENSE NUMBER:

SECTION C - AUTHORIZATION

THE PMP REGULATIONS REQUIRE THAT THE ABOVE INFORMATION BE COLLECTED; INCOMPLETE FORMS CANNOT BE PROCESSED.

I CERTIFY THAT I AM IN GOOD STANDING WITH THE PROVINCIAL LICENSING BODY AND THAT THE INFORMATION GIVEN ON THIS REGISTRATION FORM IS ACCURATE.

SIGNATURE: **DATE:**

☐ PLEASE INDICATE WITH AN **X** IF YOU **DO NOT** WANT YOUR REGISTRATION INFORMATION SHARED WITH THE PHARMACARE PROGRAM.