



PHARMACY REGISTRATION FORM

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PLEASE FAX COMPLETED FORM TO PMP 902-481-3157

SECTION A – PHARMACY INFORMATION

OPERATING NAME OF PHARMACY:

STORE NUMBER (ASSIGNED BY THE LICENSING BODY):

DATE PHARMACY OPENED (IF KNOWN):

PHARMACY SOFTWARE:

CONTACT NAME:

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

ADDRESS LINE 1:

ADDRESS LINE 2:

CITY/TOWN:

PROVINCE:

POSTAL CODE:

CONTACT TELEPHONE:

FAX NUMBER:

PHARMACY EMAIL ADDRESS:

SECTION B - AUTHORIZATION

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

I CERTIFY THAT THE INFORMATION GIVEN ON THIS REGISTRATION FORM IS ACCURATE.

SIGNATURE:

DATE:

TITLE: