PHARMACY REGISTRATION FORM

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F 902.481.3157
www.nspmp.ca

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:

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: