

APPLICATION FOR DRUG PROGRAMS INFORMATION NETWORK REGISTRATION
4 - 6 WEEKS NOTICE IS REQUIRED

1) Pharmacy Information

<input type="checkbox"/> Existing Pharmacy - Change of Ownership - Effective date: _____ <input type="checkbox"/> New Pharmacy - Opening date: _____				
Trade Name of Pharmacy		DPIN Provider Number	P	
Legal Name of Pharmacy		CPhM Pharmacy Licence Number		
Site Address (Location of Pharmacy)		Mailing Address (if different)		
City	Postal Code	City	Postal Code	
Telephone No. (Pharmacy) ()	Fax No. (Pharmacy) ()	Name of Contact	Telephone No. ()	
Pharmacy Email Address		Contact Email Address		

2) Ownership

Legal Name of Head Office		Mailing Address		
City	Postal Code	Telephone No. ()	Fax No. ()	Name of Contact

3) Type of Pharmacy

<input type="checkbox"/> Community <input type="checkbox"/> Hospital <input type="checkbox"/> Clinical Practice		COMPONENT: <input type="checkbox"/> Central Fill <input type="checkbox"/> Distance Care <input type="checkbox"/> External Dispensing <input type="checkbox"/> Satellite		
<input type="checkbox"/> Independent <input type="checkbox"/> Chain	Trade Name of Chain: _____			

I request and authorize that a copy of my Remittance Advice be forwarded to my pharmacy chain head office (check box)

4) Software Vendor Information

Vendor Name	Software Name	Software Version #
Name of Contact	Telephone No.	

5) Banking Information

You must attach a blank cheque marked "VOID"	
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6) Name(s) and address(s) of owner(s) and partner(s) (attach additional information if required)

Name(s) (Print)	Address(s)

7) Pharmacy Manager and Owner

Pharmacy Manager Name: (Print)	Owner Name: (Print)
Pharmacy Manager Signature	Owner Signature
Date	Date

**** A SIGNED PHARMACY AGREEMENT IS REQUIRED BEFORE YOUR DPIN PROVIDER NUMBER IS RELEASED ****