College of Pharmacists of Manitoba

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2018 SATELLITE PHARMACY COMPONENT APPLICATION

Name of Primary Pharmacy _____

_____
Street and/or Mailing Address City or Town Postal Code

_____
Telephone Number Fax Number

Name of Satellite Pharmacy _____
(May be the same name as the primary pharmacy name)

_____
Street and/or Mailing Address City or Town Postal Code

_____
Telephone Number Hours of Service

I hereby make application to conduct a Satellite Community Pharmacy under the provisions of the Satellite Community Pharmacy Practice Criteria of the College of Pharmacists of Manitoba for the year ending **the 31st day of December, 2018.**

The above satellite pharmacy is owned by the same owner as the Primary Pharmacy and will be conducted in accordance with the Satellite Community Pharmacy requirements of the College.

_____ _____
Date Signature of Pharmacy Manager

Fee: $546.24
GST $ 27.31
$573.55

Payment must accompany application (All fees are non-refundable) **GST No. R107660664**

o **Cheque: (Payable to the College of Pharmacists of Manitoba (CPhM))**
o **Interac: (Payment made at the CPhM Office)**
o **Visa or MasterCard Number: _ _ _ _/_ _ _ _/_ _ _ _/_ _ _ _ Expiry Date: _ _/ _ _**