College of Pharmacists of Manitoba

200 TACHE AVENUE, WINNIPEG, MANITOBA R2H 1A7
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PHARMACY TECHNICIAN
LISTING RENEWAL APPLICATION
FOR JUNE 1, 2017 TO MAY 31, 2018

(Title) (Last Name) (First Name) (Middle Initials)

(Mailing Address) (City) (Province) (Postal Code)

(Home Telephone Number) (Work Telephone Number) (Work Fax Number)

(Date of Birth) (E-Mail Address) (Cell phone)

(Primary Employer) (Address) (Pharmacy Manager)

(Secondary Employer if applicable) (Address) (Pharmacy Manager)

DECLARATIONS:

As a Pharmacy Technician, under *The Pharmaceutical Act* of the Province of Manitoba, I hereby make application for listing in the Province of Manitoba **until the 31st day of May, 2018**.

I declare that **I do** □ **I do not** □ suffer from a physical or mental condition, including an addiction to alcohol or drugs that may interfere with my ability to practice in a safe and effective manner.

AND

I declare that I will participate or have participated in a performance review with the pharmacy manager, at a minimum of once every two years, that includes: documentation of my hours worked as a pharmacy technician; an assessment of my job performance in terms of quality of patient care, administrative skills and the ability to work consistently within the rules governing the pharmacy and pharmacy practice; and, documentation of attaining the Council approved professional development requirement.

AND

I declare that I will work or have worked as a pharmacy technician for at least 600 hours in the preceding three-year period, starting three years after I have first qualified as a pharmacy technician.

AND

I declare that I have provided or will provide the pharmacy manager with evidence of my participation in the professional development program established by Council (a minimum of 15 hours of learning activities between June 1st and May 31st of each year, of which at least five hours must be from accredited learning activities).

RELEASE OF WORK MAILING ADDRESS

I give my consent to the College to provide my work mailing address to other organizations for the purpose of forwarding information by mail consistent with policy established by Council. **Yes** □ **No** □

LISTING RENEWAL FEE:

$ 51.05
$ 2.55 GST
$ 53.60

PAYMENT MUST ACCOMPANY APPLICATION…ALL FEES ARE NON-REFUNDABLE **GST# R107660664**

- □ **Cheque: (Payable to: College of Pharmacists of Manitoba)**
- □ **Interac (made at the CPhM Office)**
- □ **VISA or MasterCard Number::**_ _ _ _/_ _ _ _/_ _ _ _/_ _ _ _

Expiration Date: _____

Name of Cardholder: _____

Signature of Cardholder: _____

For Office Use Only:

Certificate #: _____

Payment: Y BY: S EMP

Date Issued:

By signing this application, I understand that it is a confirmation of information as listed on this entire application and confirmation of all of the professional declarations listed on this entire application.

Printed name of pharmacy technician: _____

Signature of pharmacy technician: _____

Date _____