Application for Registration
Courtesy Register
Locum Pharmacist

Checklist

❒ Signed copy of this checklist

❒ Application form

❒ Letter of standing from the provincial regulatory authority where you currently hold a practicing pharmacist license

❒ Sworn Statutory Declaration (page 3 of the application form)
This document must be sworn with a commissioner for oaths, notary public or lawyer. ACP has commissioner for oaths on staff – contact the ACP office if you wish to book an appointment

❒ Signed copy of the Professional Declaration of Liability Insurance Coverage (page 4 of the application form).
Pharmacists must hold a minimum of two (2) million dollars of personal professional liability insurance coverage

Malpractice Insurance Providers
Canadian Pharmacists Benefits Association- Available through RxA
780-990-0326
Canadian Society of Hospital Pharmacists
(613) 736-9733
Alberta First Insurance Services
780-468-5098
Sheppard Insurance Service Inc
780-421-1515 or 1-800-663-2242

ACP does not recommend or endorse any specific provider.

❒ Payment

❒ If you wish to apply for authorization to administer drugs by injection please see the information and application form on the ACP website (**https://abpharmacy.ca/sites/default/files/InjectionApplication.pdf**)

❒ Allow 10 business days for processing of the application. You will be advised via email once the application has been processed. A new practice permit and receipt will be mailed to the address provided.

❒ I understand that the locum pharmacist practice permit is valid for 45 consecutive days only. After which time the practice permit will expire and I will be required to reapply and pay any associated fees.

I have reviewed this checklist and have included all required material with my application.

_____ _____
Date Signature of Applicant

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Personal Information

ACP Registration Number: _____ Email: _____

_____ _____ _____
First name Middle name Surname

Address _____

_____

_____
City / Town Province Postal code

Phone Number: _____ Cell Phone Number: _____
Area code Number Area Code Number

PEBC Qualifying Exam

Exam Date: _____ Registration Number: _____

Current Employment – in Alberta only

_____ _____
Pharmacy or hospital name License #

_____ _____ _____
Address City/Town Postal code

_____ _____
Employment Start Date Employment End Date

Disclosure of Personal Information

ACP is responsible for maintaining and protecting the personal information you have provided. In some situations, legislation requires and/or authorizes ACP to collect and use or disclose your personal information; other situations require your consent.

ACP allows you to make your personal consent choices on your ACP registration profile page (**https://acp.alinityapp.com/webclient/**). Please log on and select your consent choices. If no selection is made, ACP will assume you consent to release your information for all approved purposes.

ACP's Privacy of Personal Information Policy can be viewed in full at **abpharmacy.ca**

I declare that all of the information on this application or any information supplied in support of this application is true to the best of my knowledge.

_____ _____
Date Signature of Applicant

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Statutory Declaration- Must be sworn in the presence of a commissioner for oaths, notary public or lawyer

CANADA)
PROVINCE OF ALBERTA) In the matter of application for registration with the Alberta College of Pharmacy
T0 WIT:)

I, _____, a resident of _____, in the Province of _____
(Declarant's full name) (city town of current residence)
do hereby declare that I:

- have not been found guilty of an offence under any Act regulating the practice of pharmacists or relating to the sale of drugs, or of any criminal offence;
- am not the subject of a current proceeding relating to an offence under any Act regulating the practice of pharmacists or relating to the sale of drugs, or relating to any criminal offence;
- have not been the subject of a finding of professional misconduct, incompetence or incapacity in Alberta or any other jurisdiction in relation to pharmacy or any other health profession and am not the subject of any current professional misconduct, incompetence, or incapacity proceeding in Alberta or any other jurisdiction in relation to pharmacy or any other health profession.
- have completed the following true chronological summary of educational history as noted below giving names of institutions attended, dates of attendance and degrees or diplomas earned:

INSTITUTION	LOCATION	DATE OF ENTERING	DATE OF LEAVING	DEGREE OBTAINED

I further declare that I shall provide the Registrar with the details of any of the following that relate to me and that occur or arise after my registration:

- a charge relating to an offence under any Act regulating the practice of pharmacists or relating to the sale of drugs, or relating to any criminal offence;
- a finding of guilt in relation to an offence under any Act regulating the practice of pharmacists or relating to the sale of drugs or in relation to any criminal offence;
- a finding of professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession;
- a proceeding for professional misconduct, incompetence or incapacity in any jurisdiction in relation to pharmacy or any other health profession.

I acknowledge that I shall be deemed to have not satisfied the requirements for registration if I make a false or misleading statement or representation on my application.

I make this solemn declaration conscientiously believing it to be true and knowing that it is of the same force and effect as if made under oath and by virtue of the Canada Evidence Act.

Declared before me at the _____ of _____

in the _____ of _____ _____
(Declarant's Signature)

this _____ day of _____ 20____

_____
Commissioner for Oaths in and for the Province of _____

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Professional Declaration ofLiability Insurance Coverage

13(1)*An applicant for registration as a regulated member must provide evidence of having the type and amount of professional liability insurance required by the Council.*
Pharmacists Profession Regulation, Section 13(1)

I,_____, Registration Number_____in the
(Declarant's full name)

City of _____, in the Province of _____,
(city / town of current residence) (province of current residence)

hereby acknowledge that:

- as a regulated member on the courtesy register of the Alberta College of Pharmacy, I am in possession of valid professional liability insurance for the practice of pharmacy that provides me no less than two million dollars worth of personal coverage that is either claims-made or occurrence-based in nature;
- I understand that while on the courtesy register, I must maintain valid professional liability insurance coverage of no less than two million dollars and that if I am unable to provide proof of insurance, my practice permit may be cancelled;
- I understand that while I am registered on the courtesy register, I must maintain valid professional liability insurance coverage regardless of whether I am working or residing in Alberta;
- I understand that my professional liability insurance coverage must be personal and must provide coverage for me wherever I practice pharmacy in Alberta, regardless of whom my employer is; and
- I understand that the status of my insurance coverage is subject to audit and that false or misleading statements concerning my coverage may be referred to the Complaints Director for further investigation and may result in a recommendation that my practice permit be cancelled.

I declare that I have read the above and understand the requirements for professional liability insurance.

_____ _____
Date Signature of Declarant

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Fee Payment:

Applicants Name: _____ Registration Number: _____

Locum Fee (locum practice permit is valid for 45 consecutive days only)

Practice Fee	424.00
GST	21.20
Total	**$445.20**

Choose the form of payment that applies to this registration.

_____ A: Cheque # _____

_____ B: Credit Card (complete below)
(Visa or MasterCard Only)

|___|___|___|___| |___|___|___|___| |___|___|___|___| |___|___|___|___| |___|___| ___|___|

Credit Card # Expiry Date: (MM/YY)

Cardholder's signature: _____ Date:_____

Printed Name: _____

Cardholder's phone #: _____ Cell: _____

Area code-phone # Area code-phone #

For Office Use Only Date Transaction Processed: _____