

ALL SECTIONS OF THIS FORM MUST BE COMPLETED

PHARMACIST INFORMATION		
Last Name	First Name and Initial	Professional Registration #
Confidential E-mail Address		

PRIMARY PLACE OF EMPLOYMENT (highest number of work hours accumulated at this location)			
Name of Place of Employment		Pharmacy License # / Hospital Unit (if applicable)	
Site Address	City	Province	Postal Code
Phone Number ()	Fax Number ()		

SECONDARY PLACE OF EMPLOYMENT (if applicable)			
Name of Place of Employment		Pharmacy License # / Hospital Unit (if applicable)	
Site Address	City	Province	Postal Code
Phone Number ()	Fax Number ()		

TERTIARY PLACE OF EMPLOYMENT (if applicable) **			
Name of Place of Employment		Pharmacy License # / Hospital Unit (if applicable)	
Site Address	City	Province	Postal Code
Phone Number ()	Fax Number ()		

**If additional writing space is required regarding place of employment, please attach a separate piece of paper.

SIGNATURE (to be completed by the Pharmacist)	
Signature	Date (YYYY / MM / DD) / /

Please return your fully completed form to: **Attention: Pharmacy Agreement Coordinator**
 Alberta Blue Cross
 10009 108 Street,
 Edmonton, AB T5J 3C5

or fax to:
780-498-8384 (Edmonton)
1-877-828-4106 (Toll-free all other areas)

Upon registration with Alberta Blue Cross, pharmacists with “additional prescribing authorization” will be eligible to complete, sign and submit Special Authorization requests, when they are the prescriber, in accordance with Special Authorization criteria.

This eligibility will apply to Special Authorization drug products that the pharmacist is authorized to prescribe with the exception of products for which a specialist must submit the request. Details about specific Special Authorization criteria can be found in the *Alberta Drug Benefit List*.

FOR ALBERTA BLUE CROSS USE ONLY	
Date effective	Date processed