PHARMACIST PRESCRIBER SPECIAL AUTHORIZATION REGISTRATION FORM

ALL SECTIONS OF THIS FORM MUST BE COMPLETED

PHARMACIST INFORMATION		
Last name	First name and initial	Professional registration #
Confidential email 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:
780-498-3549

FOR ALBERTA BLUE CROSS USE ONLY	
Date effective	Date processed