

## PHARMACIST PRESCRIBER SPECIAL AUTHORIZATION REGISTRATION FORM

## ALL SECTIONS OF THIS FORM MUST BE COMPLETED

PHARMACIST INFORMATION				
Last name	First name and initi	ial	Professional registration #	
Confidential email address				
PRIMARY PLACE OF EMPLOYMENT (high	est number of work h	ours accumulated at	this location	)
Name of place of employment		Pharma	icy license # /	hospital unit (if applicable)
Site address	City	F	Province	Postal code
Phone number	Fax number			
( )	( )			
SECONDARY PLACE OF EMPLOYMENT (if applicable)				
Name of place of employment		Pharma	icy license # /	hospital unit (if applicable)
Site address	City	F	Province	Postal code
Phone number	Fax number			
( )	( )			
TERTIARY PLACE OF EMPLOYMENT (if a	pplicable) **			
Name of place of employment		Pharma	icy license # /	hospital unit (if applicable)
Site address	City	F	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 (YYY)	Y / MM / DD)		
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lease 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	Data processo d			
Date effective	Date processed			

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