



**PHARMACISTS
ANNUAL RENEWAL FORM**

Professional Licensing and Regulatory Affairs C-5
 P.O. Box 2703
 Whitehorse, YT, Y1A 2C6

* Fees are due on or before **March 31**.
Questions? Call the Licensing Officer at 867-667-5940

PERSONAL INFORMATION	FEES & PAYMENT OPTIONS
Yukon Registration Number (as stated on your licence): _____	Renewal fee <input type="checkbox"/> \$ 100 Reinstatement fee if renewed after Mar. 31 <input type="checkbox"/> \$ 110 Renewals will be processed only if they include the correct fees. Paying by cheques: Make payable to Government of Yukon OR Paying by credit card: complete payment information form at: http://www.gov.yk.ca/forms/cs.html#cs1
Family Name Given Name Previous Name	NOTE: Professional Licensing and Regulatory Affairs will NOT accept payment by email or fax.
Home Mailing Address	
City Territory/Province Postal Code	<input type="checkbox"/> Female <input type="checkbox"/> Male Year of birth: _____
Home Telephone Number	
Email Address	

REMOVAL

Complete this section only if you no longer wish to be registered as a Pharmacist in Yukon.

I am no longer practising pharmacy in Yukon and request that my name be removed from the pharmacy register.

Date: _____ Signature: _____

EMPLOYMENT STATUS

Indicate below your current employment status:

Employed in the profession of pharmacy Unemployed and seeking employment in the profession of pharmacy
 Employed in other than pharmacy and seeking employment in the profession of pharmacy Unemployed and not seeking employment in the profession of pharmacy
 Employed in other than pharmacy and not seeking employment in the profession of pharmacy

RANGE OF ESTIMATED WEEKLY PRACTICE HOURS

Complete this section for each employer separately if you have more than one employer.

PRIMARY EMPLOYMENT	SECOND EMPLOYMENT	THIRD EMPLOYMENT
<input type="checkbox"/> 40 and above <input type="checkbox"/> 30 - 39 <input type="checkbox"/> 15 - 29 <input type="checkbox"/> 14 or less	<input type="checkbox"/> 40 and above <input type="checkbox"/> 30 - 39 <input type="checkbox"/> 15 - 29 <input type="checkbox"/> 14 or less	<input type="checkbox"/> 40 and above <input type="checkbox"/> 30 - 39 <input type="checkbox"/> 15 - 29 <input type="checkbox"/> 14 or less

Number of hours spent on continuing education (CE) during the last licensing year: _____

Subject/Course: _____ Date: _____

Subject/Course: _____ Date: _____

Please use separate sheet if necessary.

EMPLOYMENT CATEGORY

Complete this section for each employer separately if you have more than one employer.

PRIMARY EMPLOYMENT	SECOND EMPLOYMENT	THIRD EMPLOYMENT
<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary ¹ <input type="checkbox"/> Casual ² <input type="checkbox"/> Self-employed	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Casual <input type="checkbox"/> Self-employed	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Casual <input type="checkbox"/> Self-employed
Name of pharmacy (business name): _____	Name of pharmacy (business name): _____	Name of pharmacy (business name): _____
Postal Code: _____	Postal Code: _____	Postal Code: _____
Direct Phone: _____	Direct Phone: _____	Direct Phone: _____

¹ Temporary: fixed duration of temporary employment with guaranteed work hours² Casual: employed on an as-needed-basis with no guaranteed or fixed work hours**EMPLOYMENT SETTING**

If you have more than one employer, use "A" to indicate primary employment, "B" to indicate second employment and "C" for third employment. Please choose only one per employment setting.

POSITION

For pharmacists with multiple roles in a place of employment, identify the position associated with the most worked hours for the primary ("A"), second ("B") and third ("C") employment

- Director of Pharmacy (little or no direct client service provision)
 Pharmacy Manager (day-to-day operation with significant direct client service provision)
 Pharmacy Owner/Manager (owner with major role in day-to-day operation; may include some direct client service)
 Staff Pharmacist
- Industrial Pharmacist
 Pharmacist Consultant
 Educator
 Institutional Leader/Coordinator
 Researcher
 Other

PLACE OF EMPLOYMENT

- Hospital or other health care facility
 Community Pharmacy
 Other Pharmacy
 Group professional practice/clinic
- Community Health Centre
 Other Community-based Pharmacist Practice
 Post-secondary educational institution
- Association/Government/Para-government
 Health-related industry / manufacturing / commercial
- Community Pharmacy Corporate Office
 Other

EDUCATION

Level of basic education in Pharmacy: Diploma Baccalaureate Master's PharmD ^a

Year of Graduation: _____ Canadian University: _____

Province / Country of Graduation: _____

Highest level of post-basic education in Pharmacy:

- Baccalaureate Master's PharmD Doctorate Accredited Residency^b

Year of Graduation: _____ Canadian University: _____

Province of Graduation for Accredited Residency in Pharmacy: _____

Country of Graduation for highest level of post-basic education in Pharmacy: _____

^a PharmD: A clinical/practice-based post-graduate level university degree in Pharmacy

^b Accredited Residency: An organized, directed post-graduate training program in a defined area of pharmacy practice

ATTACHMENTS

In support of my renewal application, I enclose:

1. Completed renewal form (original)
2. Required Registration Fees
3. Letter of Standing from each jurisdiction in which I was licensed during the past year.

DECLARATION

Answer each of the following questions and statements by indicating "Yes" or "No".

Is your professional conduct and your practice of pharmacy under investigation in any jurisdiction outside Yukon? Yes No

Are you the subject of disciplinary proceedings in any jurisdiction outside Yukon? Yes No

Have you been licensed to practise pharmacy in one or more jurisdictions other than Yukon during the past year?

Yes No If yes, where? _____
(Letter of Standing required from each jurisdiction)

Do you have a criminal record? Yes No If yes, please provide a brief narrative.

Is the information you provided on this form true, accurate and complete? Yes No

I authorize the payment by credit card as indicated on Page 1 of this form. Yes
 Not applicable

I confirm that I have read and understand these declarations. Yes No

Date: _____ Signature: _____

The information collected by this form is used to determine eligibility for licensure, to maintain the Yukon Register of Pharmacists and for research and statistical purposes related to health human resource planning. The information will be disclosed only in accordance with the *Personal Information Protection and Electronic Documents Act (PIPEDA)* and the *Access to Information and Protection of Privacy Act (ATIPP)*.

ADDITIONAL INFORMATION YOU WISH TO PROVIDE

FAILURE TO RENEW REGISTRATION

Section 16 of the *Pharmacists Act* states that if a registrant fails to apply for and pay the fee for the renewal of their licence by March 31, the registrant's name will be removed from the register.

Practising pharmacy in Yukon without a licence is an offence under the *Pharmacists Act* according to Section 13.