**PRINCE EDWARD ISLAND PHARMACARE**
**PARTICIPATING PHARMACY APPLICATION**

**Personal information on this form is collected under the *Drug Cost Assistance Act* and Regulations. This information is required to process your application to participate in the delivery of Prince Edward Island Pharmacare Drug Programs. If you have any questions about this collection of personal information, you may contact the PEI Pharmacare office.**

| **Name of Pharmacy:** | **PEI Pharmacy License Number:** |
|---|---|
| | |

| **Mailing Address:** | **Address (if different from mailing):** |
|---|---|
| | |

| **Telephone Number:** | **Fax Number:** | **Email Address:** |
|---|---|---|
| | | |

**Contact Person (include telephone number and email address if different from above):**

**I agree to abide by the terms and conditions of any current agreements between the Government of Prince Edward Island and the PEI Pharmacists Association for delivery of Prince Edward Island Pharmacare Drug Programs.**

**I have read and understand the requirements of a custodian as described in the *Health Information Act*.**

**I understand and agree to abide by the requirements for the submission and adjudication of prescription information and claims as identified in the *Drug Cost Assistance Act* Regulations and the *Health Information Act* Regulations.**

**I agree to provide Prince Edward Island Pharmacare with a minimum of thirty (30) days written notice of any changes to ownership or location of the above named pharmacy.**

**I agree to provide a minimum of ninety (90) days written notice of intention to withdraw from participation in Prince Edward Island Pharmacare Drug Program delivery, and such notice shall become effective on the first day of the month of expiration ninety (90) days after the day on which Prince Edward Island Pharmacare receives such written notice.**

**I agree to notify Prince Edward Island Pharmacare of any changes to the usual and customary charges in effect in the above named pharmacy.**

**The following represents an accurate statement of the usual and customary charge formula in effect for the above named pharmacy on the date of signing this agreement:**

| | | | |
|---|---|---|---|
| **Regular prescription products:** | **_____** | **Extemporaneous compounds:** | **_____** |
| **Oral contraceptives:** | **_____** | **Non-prescription (OTC) products:** | **_____** |
| **Insulin:** | **_____** | **Diabetic supplies:** | **_____** |

| **Signature of Permit Holder/ Manager:** | **Date:** |
|---|---|
| | |

**SEND COMPLETED AND SIGNED AGREEMENT TO:**
**PEI Pharmacare, Health PEI**
**PO Box 2000**
**Charlottetown, PE C1A 7N8**
**Fax: (902) 368-4905**

**FOR OFFICE USE ONLY**

**Pharmacy Billing Number(Assigned): _____** **Effective Date: _____**
**Entered By: _____** **Date Entered: _____**