New Brunswick College of Pharmacists
Ordre des pharmaciens du Nouveau-Brunswick

Governing the practice of pharmacy for a healthier New Brunswick

Régir l'exercice de la pharmacie pour un Nouveau-Brunswick en meilleure santé

CENTRAL FILL PHARMACY
AGREEMENT NOTIFICATION FORM
Intent to Utilize Centralized Drug Order Processing

A copy of this agreement notification form must be filed with the NBCP. A new notification form **must** be filed if any changes occur to the information provided below.

Date of Notification: _____

THIS AGREEMENT IS BETWEEN:

Originating Pharmacy	**Centralized Processing Pharmacy**
Pharmacy name:	Pharmacy name:
Certificate of Operation #:	Certificate of Operation #:
Pharmacy address:	Pharmacy address:
Pharmacy Telephone #:	Pharmacy Telephone #:
Pharmacy email address:	Pharmacy email address:
Proposed date for start of Centralized Drug order processing:	Proposed date for start of Centralized Drug order processing:
Pharmacy Manager name:	Pharmacy Manager name:
Pharmacy Manager NBCP License #:	Pharmacy Manager NBCP License #:
I certify that there is a written agreement between the pharmacies named and I understand the responsibilities and will comply with the NBCP Centralized Drug Order Processing (Central Fill) Practice Directive.	
x	x
Originating Pharmacy -Signature of Pharmacy Manager	Central Fill Pharmacy- Signature of Pharmacy Manager
Date:	Date:

Completed form must be submitted to registrations@nbpharmacists.ca