



## REQUEST FOR LETTER OF COLLABORATION - COLLABORATIVE PRACTICE

**Instructions:** You are being asked to complete this form by a pharmacist who is seeking to formalize a collaborative practice arrangement.

By completing this form on the pharmacist's behalf, you are contributing to their application by describing the collaborative working relationship they have developed with you. Please describe the nature of your collaborative relationship with the pharmacist by choosing "Yes" or "No" for each of the criteria below. Please also provide a brief example or description of how your collaborative relationship fulfills the criteria.

Name of pharmacist:

The pharmacist and I have agreed upon the scope of this collaborative practice.	Yes      No
Description of this agreement:	
The pharmacist and I have developed protocols to determine mutual goals of therapy for each patient.	Yes      No
Example or description	
The pharmacist and I have established methods of regular communication which are effective and timely.	Yes      No



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

686 boul. St-George Blvd, Suite 200  
Moncton, N.-B. E1E 2C6  
Tel: (506) 857-8957 Fax / Téléc: (506) 857-8838  
[www.nbpharmacists.ca](http://www.nbpharmacists.ca) [info@nbpharmacists.ca](mailto:info@nbpharmacists.ca)

Example or description

Additional comments (if required): (Use additional paper if necessary)

#### SIGNED STATEMENT

I confirm that the information I have provided above regarding my collaborative working relationship with the pharmacist is true and accurate to the best of my knowledge.

Signature:	Date:
Name:	Title:
Company/Institution Name:	Company address:
Phone number:	E-mail address:

Once you have completed the form, please provide the original to the pharmacist, or email the College directly: [registrations@nbpharmacists.ca](mailto:registrations@nbpharmacists.ca)