BRITISH COLUMBIA | Ministry of Health

COMMUNITY HEALTH PRACTITIONER REQUEST FOR ACCESS TO PHARMANET

The Ministry of Health collects registration information from applicants for the purposes of authenticating and authorizing access to Ministry services and to monitor all users to ensure integrity of the system and of the information, collected, used, and disclosed as permitted under the *Pharmaceutical Services Act*. Personal information on this form is collected under section 26 (c) of the *Freedom of Information and Protection of Privacy Act*.

Before completing and submitting this form online, please print and read the instructions and advisories at www.gov.bc.ca/pharmanetaccess/communitypractitioners.

Notes: Complete this form ***only*** if you are a licensed physician or nurse practitioner who delivers direct patient care in a community practice.

Do not use this form to apply for access to PharmaNet in health authority owned and operated facilities (hospitals, emergency departments, licensed residential care facilities, etc.).

FOR OFFICE USE ONLY (Organization No.)

SECTION 1: PRACTITIONER INFORMATION

Practitioner First Name	Practitioner Middle Name	Practitioner Last Name

Practitioner Email Address	MSP Practitioner Number (aka Billing Number) if you have one

College Name	Practitioner College ID (licence number)	Licence Expiry Date

Class of Registration with your College *(i.e., the type of licence you have been granted)*

☐ I have already signed a Practitioner Agreement for the Electronic Health Record Pilot Project.

SECTION 2A: PRIMARY PRACTICE SITE

Practice Name (as it appears on the business licence)	Office Phone Number (with area code)	Office Fax Number (with area code)

Office Street Address (Unit #, Building #, Street Name, Street Direction, if applicable)	City	Postal Code

Software used to Access PharmaNet at this Site *(check the appropriate box)*

☐ Commander Group ☐ iClinic Inc. ☐ Plexia Electronic Medical Systems

☐ Excelleris ☐ Medinet ☐ St. Joseph's General Hospital

Supervised Persons at this site who will access PharmaNet on your behalf

First Name	Middle Name	Last Name	Job Title

Health Data Access Services
Ministry of Health
PO BOX 9654
STN PROV GOVT
Victoria BC V8W 9P4
Fax: 250-405-3628

SECTION 2B: SECOND PRACTICE SITE (if applicable)

Practice Name (as it appears on the business licence)	Office Phone Number (with area code)	Office Fax Number (with area code)

Office Street Address (Unit #, Building #, Street Name, Street Direction, if applicable)	City	Postal Code

Software used to Access PharmaNet at this Site *(check the appropriate box)*

☐ Commander Group ☐ iClinic Inc. ☐ Plexia Electronic Medical Systems
☐ Excelleris ☐ Medinet ☐ St. Joseph's General Hospital

Supervised Persons at this site who will access PharmaNet on your behalf

First Name	Middle Name	Last Name	Job Title

SECTION 2C: THIRD PRACTICE SITE (if applicable)

Practice Name (as it appears on the business licence)	Office Phone Number (with area code)	Office Fax Number (with area code)

Office Street Address (Unit #, Building #, Street Name, Street Direction, if applicable)	City	Postal Code

Software used to Access PharmaNet at this Site *(check the appropriate box)*

☐ Commander Group ☐ iClinic Inc. ☐ Plexia Electronic Medical Systems
☐ Excelleris ☐ Medinet ☐ St. Joseph's General Hospital

Supervised Persons at this site who will access PharmaNet on your behalf

First Name	Middle Name	Last Name	Job Title

SECTION 3: YOUR MAILING ADDRESS

Check your preferred mailing address for receipt of legal and/or other notices

Same as: ☐ Primary Practice ☐ Secondary Practice ☐ Third Practice ***OR*** ☐ Use address below for all legal and other notices

Office Street Address (Unit #, Building #, Street Name, Street Direction, if applicable)	City	Postal Code

SECTION 4: CERTIFICATION

By signing below and submitting this form, I hereby certify that

- all information provided on this form is true and I understand that the Ministry of Health and/or Health Insurance BC (HIBC) may verify this information with my regulatory body, software vendor, and others as required, and
- I have confirmed that all of the supervised persons who will access PharmaNet on my behalf (listed above) have signed the appropriate *Undertaking of Confidentiality and Security*.

Signature	Name (print or type)	Date

SECTION 5: SUBMISSION

You are required to print 2 copies of this form – one to sign and attach to the signed Community Health Practitioner PharmaNet Access Agreement (HLTH 4532) and one for your records.

1. Click "Print" and print two copies of the completed form.
2. Click "Submit" to send an electronic copy to the Ministry to initiate the process. **Note**: Access cannot be granted until the signed copy of this form is received.
3. Fax the completed signed copy of the form and the signed Community Health Practitioner PharmaNet Access Agreement (HLTH 4532) to 250-405-3628 or send by regular mail to the address noted on the bottom of page 1.

PRINT SUBMIT CLEAR FORM