

Attach 1 photo with date taken stamped on the back

Application for the Pharmacists Document Evaluation

FOR OFFICE USE ONLY:
PEBC IDENTIFICATION #: _____

Do Not Write in this Space!

Mail to: The Pharmacy Examining Board of Canada, 717 Church Street, Toronto, Ontario M5G 1K8
All information must be clearly printed or typewritten.

Family Name as on Birth Certificate (or Marriage Certificate)

University you attended

Dates you attended University

Degree Obtained

Surname _____
Given Names _____
 Ms. Miss Mrs. Mr.

Name BEFORE Marriage if different from current Surname

Academic Record
Include academic year and degree expected/received:

Faculty and University	Dates From/To	Degree(s)

EXAMPLE

Given Names _____
Former Surname (if applicable) _____

Address _____

Postal Code _____
Area Code, Home Telephone number & cell number _____

If possible, please supply Email address

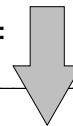
Email _____
Date of birth (day / month / year) _____

Licensing Record

Country	Licensing Body	Date Licensed
Country where you were MOST RECENTLY licensed	Name of Licensing Authority	

Date of expected entry into Canada: _____

Province of expected residence: _____



Declaration

I hereby declare that all the information given in this application and in all documents submitted herewith is true and accurate and that the attached photograph is a recent photograph of myself (within six months). I also declare that I am the person referred to in the documents which are being submitted in support of this application.

I understand that falsification of this application, submission of falsified documents to The Pharmacy Examining Board of Canada, (hereinafter referred to as "the Board"), or submission of falsified Board documents to other agencies may be sufficient cause for the Board to bar me from the Evaluating Examination or to take appropriate action as it sees fit.

I declare I am not now, nor ever have been, suspended by my pharmacy association, nor have I ever been convicted of any breach of any pharmacy act or regulations or of any of the acts governing the practice of pharmacy. I have been engaged in the practise of pharmacy for _____ years.

I also understand that the accompanying fee cannot be refunded, except under special circumstances defined by the Board.

I hereby authorize the Board to divulge any information contained in this application to any authority who, in the opinion of the Board, has a legitimate interest in such information.

I make this solemn declaration conscientiously believing it to be true and knowing that it is of the same force and effect as if made under oath.

Signature of Applicant _____

Declared before me at (city and date) _____

Signature of Notary Public or Commissioner for Oaths or Lawyer or Canadian Embassy _____

Number of years practising as a pharmacist

Sign in front of proper witness

Notary public, commissioner for oaths, lawyer or Can. Embassy representative signs in BOTH places

ATTACH ONE PASSPORT SIZE PHOTOGRAPH HERE.

Seal, stamp or signature of witness must cover a portion of the photograph and application.

Do Not Write in this Space!

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FEE PAID _____

DATE PAID _____

CR _____