COLLEGE OF
NATUROPATHIC PHYSICIANS
OF BRITISH COLUMBIA

2015 Certification in Prescribing Authority Application Form

(please read and complete both pages of this form)

I have completed and passed the course and examination in prescribing that was administered by the Boucher Institute of Naturopathic Medicine. I understand that as a Full/Practicing registrant with prescribing authority, I am gaining the *privilege* of prescribing authority. I understand that my certification may be suspended or revoked by the Board of the CNPBC at the recommendation of the Inquiry Committee, Discipline Committee or Quality Assurance Committee. I agree to pay a certification fee of $100, and any other fees levied by the Board. I agree to fulfill continuing education requirements, and adhere to the Health Professions Act, current CNPBC bylaws and current Code of Ethics, Code of Conduct, and Standards of Practice and the CNPBC Certification Policy for Prescriptive Authority. I further understand that to comply with the Health Professions Act, Criminal Records Review Act and bylaws, I must supply to the College all contact information including my current home and office; address, fax and phone numbers and authorize the CNPBC to use this information in compliance with these Acts.

I understand that any violation of the Standards, Limits, and Conditions on Prescribing, Compounding and Dispensing may result in revocation or suspension of my prescribing privileges, or my registration, in accordance with CNPBC policies. If I am charged with or convicted of a criminal offence at any time subsequent to this application, I agree to report the charge or conviction to the Registrar of the CNPBC in a timely manner, and will provide the CNPBC with an explanation of the charge or conviction.

I understand that I may not prescribe drugs until the CNPBC has confirmed my certification in prescribing authority and assigned to you a prescribing number.

By signing below, I certify that I have read the above statement and agree to the terms stated herein.

_____ Date: ____/____/____
day mo year

Signature (Original signature is mandatory)

✉ Suite 840, 605 Robson Street, Vancouver, BC V6B 5J3
☎ (604) 688-8236 Fax (604) 688-8476
e-mail:office@cnpbc.bc.ca website:http://www.cnpbc.bc.ca

**** REQUIRED INFORMATION - Please Print***

Last Name : _____ First Name :

Age : Date of Birth : (dy)____/(mo)____/(yr)__ Clinic Name

Clinic Address _____

City : Postal Code : _____ - _____

Telephone : (Work) Fax : (Work)

Home Address _____

City : Postal Code : _____ - _____

Telephone : (Home) Fax : (Home)

Email Website:

PAYMENT OPTIONS

Please check the box of your choice for the method of payment.

☐ Enclosed is a **bank draft or certified cheque in the amount of** $100.

☐ I elect to pay $100 by credit card and authorize the CNPBC to use the information below:

Visa/MC Account # _____Expiry: (mo) _____/ (yr) _____

3 digit Visa/MC security number _____

Registrant's signature: _____ Date: ____/____/____
day mo year

IMPORTANT NOTE – The completed application should include this form with original signature, proof of passing the pharmacy examination from BINM and payment of $100.00

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