OUT - OF - PROVINCE PRESCRIBER REGISTRATION FORM

PO Box 2200, Halifax NS B3J 3C6
T 902.496.7123 **TF** 1-877-476-7767
F 902.481.3157
www.nspmp.ca

SECTION A — CONTACT INFORMATION

SURNAME:	FIRST NAME:	MIDDLE NAME:
DATE OF BIRTH: ____/__ __/______ DD / MM / YYYY	COUNTRY OF BIRTH:	GENDER:

OFFICE ADDRESS (DUPLICATE PADS WILL BE SENT TO THIS LOCATION):	**CORRESPONDENCE ADDRESS** (OPTIONAL):
NAME (AS YOU WOULD LIKE IT TO APPEAR ON PADS)	ADDRESS LINE 1:
ADDDRESS LINE 1	ADDRESS LINE 2:
ADDRESS LINE 2:	
CITY/TOWN: / PROVINCE:	CITY/TOWN: / PROVINCE:
POSTAL CODE:	POSTAL CODE:
TELEPHONE:	TELEPHONE:
FAX NUMBER:	FAX NUMBER:
EMAIL (OPTIONAL):	EMAIL:

SECTION B — EDUCATION AND LICENSING INFORMATION

ORIGINAL MEDICAL/DENTAL/NURSING DEGREE

GRANTING UNIVERSITY:	COUNTRY:	GRADUATION YEAR:

PROVINCIAL LICENSE/REGISTRATION NUMBER:	MEDICAL IDENTIFICATION NUMBER OF CANADA (MINC) IF APPLICABLE:

SECTION C — TYPE OF PRACTICE

PLEASE LIST YOUR CURRENT PRACTICE SETTING/SPECIALTY OR SPECIALTIES:

DO YOU PRACTICE IN A CLINICAL GROUP SETTING? (PLEASE CIRCLE) YES NO

IF YES, PLEASE *PRINT OR ATTACH LETTERHEAD* WITH THE NAMES OF THE OTHER PROVIDERS THAT MAY PRESCRIBE FOR YOUR PATIENTS:

SECTION D - AUTHORIZATION

THE PRESCRIPTION MONITORING BOARD REQUIRES THAT THE ABOVE INFORMATION BE COLLECTED; INCOMPLETE FORMS CANNOT BE PROCESSED.

I UNDERSTAND THAT BY REGISTERING WITH THE NOVA SCOTIA PRESCRIPTION MONITORING PROGRAM I WILL BE IDENTIFIED AS A PRESCRIBER ON ALL MY PRESCRIPTIONS (NOT JUST MONITORED PRESCRIPTIONS) RECORDED IN THE NOVA SCOTIA DRUG INFORMATION SYSTEM.

I CERTIFY THAT I AM IN GOOD STANDING WITH MY PROVINCIAL LICENSING BODY AND THAT THE INFORMATION GIVEN ON THIS REGISTRATION FORM IS ACCURATE.

SIGNATURE: **DATE:**