Prince Edward Island Pharmacists Association

E-transfers Accepted
Send your Registration Form & Payment electronically.

Pharmacist Membership Registration April 1, 2018-March 31, 2019

COMPLETE AND RETURN THIS FORM ALONG WITH PAYMENT.
Please make cheques payable to the PEI Pharmacists Association.
Email: peipharm@gmail.com Mail: PEI Pharmacists Association Inc., PO Box 24042, Stratford, PE C1B 2V5.

Name_____

Address _____

Workplace _____

Email (required) _____ Telephone _____

A. Membership Dues: PEI Pharmacists Association

($**295.00** + $44.25 HST = $339.25) **(A)**

A	$339.25

Canadian Pharmacists Association (CPhA) membership fee included in your Dues!

B. Choose your Personal Liability Insurance Limit

B	

CPBA Personal Malpractice Limit	Premium **(B)**
☐ $2 000 000 per occurrence/$4 000 000 aggregate	$ 130.00
☐ $5 000 000 per occurrence/$5 000 000 aggregate	$ 225.00
☐ Insurance Not Required (Other coverage** or Part B Registry)	n/a
☐ Complementary (secondary insurance option-see below) **	$ 35.00

(HST# 80513 0390 RT0001)

TOTAL A + B

**COMPLEMENTARY INSURANCE OPTION:

**Members with other coverage may purchase a complementary policy ($3 000 000 per occurrence/$5 000 000 aggregate) for the great rate of $35 that will cover any possible gaps to their employer's policy and/or increase limits of an employer's policy. Contact the Association for more details.

Required: Name of your employer or affiliate: _____**Insurer:** _____

Current primary policy number: _____ **& Limit of primary coverage:** _____

Please Answer the Following:

Has a Pharmacist malpractice claim ever been made against you and/or the pharmacy you have been affiliated with? ___ Yes ____No

Are you aware of any incidents or circumstances which could lead to a claim? ___ Yes ____No

The PEI Pharmacists Association (PEIPhA) is seeking your express consent to stay in touch with you electronically.
I agree to receive PEIPhA email communications which include newsletters, notifications and updates containing information about PEIPhA and its partners. You can withdraw or provide your consent at any time by contacting the Association. ____ Yes ____No

The PEI Pharmacists Association can share the information provided with CPhA for membership purposes. ____ Yes ____No

DECLARATION:
I declare that the above statements are true & that I have not omitted or suppressed or misstated any material facts.

Signature _____ Date _____

All personal information collected on this form will be handled in accordance with our Privacy Policy, found at www.peipharm.info.

PEI Pharmacists Association Inc.
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