Pharmaceutical Information Program
Application for Correction

Form 2

Pharmaceutical Information Program
PO Box 2000
Charlottetown, PE C1A 7N8

Personal information on this form is collected under the *Pharmaceutical Information Act* and Regulations. This information is required in order to process your application for disclosure of information. If you have any questions about this collection of personal information, you may contact the Director of the Pharmaceutical Information Program.

Name (Last name, given name)	**Provincial Health Number** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
Mailing address Province Postal code	**Date of birth** --------/---------/--------- day / month / year	**Gender** ☐ male ☐ female
Telephone number	**Current PhIP password** (for office use only) ☐ ☐ ☐ ☐ ☐ ☐	

Identification (attach copy)

☐ birth certificate ☐ drivers licence ☐ (other)_____

If corrections are required for person other than applicant:

Parent/Guardian's name Telephone Number

Mailing address

Corrections/Additions requested:

Date	Name of prescriber/pharmacy	Change requested	Reason for change

□ medication history attached □ additional changes attached

I am requesting the listed corrections be made to my medication history. I understand this will require the Pharmaceutical Information Program to review the changes I am requesting and I give permission to the Pharmaceutical Information Program to contact me and my prescribers, pharmacies and pharmacists, as needed, to verify the requested corrections.

Date	Signature