

## Pharmaceutical Information Program Application for Password

Form 3

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.

	the Director of the i	marmaceuticai information Frogram.	
Name (Last name, given name)		Provincial Health Number	
Mailing address		Date of birth	Gender
Province Postal code		day / month / year	□ male □ female
Telephone number		Current PhIP password (for office use only)	
Identification (attach copy)		Requested PhIP Password (for office use only)	
□ birth certificate □ drivers	licence		
(other)			
		(minimum 4 numbers, maximum 6 numbers)	
If password is required for person other than applicant:  Parent/Guardian's name  Telephone Number			
Mailing address			
I understand that once my password is a I personally provide this password. The have not provided my password cannot prescribers may refuse service without	e effect of this pas see my medicati	ssword is that pharmacists and p	participating prescribers to whom I
I understand that if I forget my passwor password more often than four times pe		for a new password. However	, I understand that I cannot apply for a
I understand my password can be overridden in an emergency.			
Date		Signature	