



International Pharmacy Graduate (IPG) Membership Form

Pharmacy Association of Nova Scotia

IPG Member Information	
Name: _____	NSCP #: _____
Home Address: _____ _____	Telephone: (H) _____ (W) _____
City: _____ Province: _____	Fax: _____
Postal Code: _____	
Business Name: _____	Year Graduated: _____
Business Address: _____ _____	
City: _____ Province: _____	
Postal Code: _____	
Email: _____	

Membership Type	FEES												
<p>IPG Non-Voting Status (includes Malpractice Insurance)</p> <p>NOTE: IPG's must first become registered as a Qualifying Intern with the Nova Scotia College of Pharmacists</p> <p>If you are working in a hospital setting your employer may require additional liability insurance. Please check with your employer re the amount required.</p>	<table style="width:100%; border-collapse: collapse;"> <tr> <td>PANS Fee includes Dal CPE Levy of \$31.25</td> <td style="text-align: right;">\$270.00</td> </tr> <tr> <td>HST on PANS Fee including Dal CPE Levy</td> <td style="text-align: right;">\$40.50</td> </tr> <tr> <td>+ Liability Insurance (\$2,000,000.00 coverage)</td> <td style="text-align: right;">\$150.00</td> </tr> <tr> <td style="text-align: right;">= PANS Membership</td> <td style="text-align: right;"><u>\$460.50</u></td> </tr> <tr> <td>Optional Additional Coverage</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td style="text-align: right;">Total:</td> <td style="text-align: right;">\$ _____</td> </tr> </table> <p style="text-align: center;">HST # 108092438</p>	PANS Fee includes Dal CPE Levy of \$31.25	\$270.00	HST on PANS Fee including Dal CPE Levy	\$40.50	+ Liability Insurance (\$2,000,000.00 coverage)	\$150.00	= PANS Membership	<u>\$460.50</u>	Optional Additional Coverage	\$ _____	Total:	\$ _____
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+ Liability Insurance (\$2,000,000.00 coverage)	\$150.00												
= PANS Membership	<u>\$460.50</u>												
Optional Additional Coverage	\$ _____												
Total:	\$ _____												

Membership runs from January 1st to December 31st

Signature
I, the undersigned, request annual membership in the Pharmacy Association of Nova Scotia as indicated above:
Signature: _____ Date: _____

Please forward completed Membership Form along with payment to:

Pharmacy Association of Nova Scotia
 170 Cromarty Drive, Suite 225
 Dartmouth, NS B3B 0G1
Phone: (902) 422-9583 Fax: (902) 422-2619

OFFICE USE ONLY	
Date Approved: _____	Receipt #: _____