COLLEGE OF PHARMACY
OF NEWFOUNDLAND AND LABRADOR

Pharmacy Owner Information Form: Corporation or Partnership

PLEASE PROVIDE THE COMPLETED AND SIGNED FORM TO THE PHARMACIST-IN-CHARGE FOR SUBMISSION TO CPNL

Owner Information:

Corporation/Partnership Name (registered business name)

Operating Name (trade name)

Ownership Structure:

☐ Non-Publicly Traded Corporation
(Complete Part A below and Part B if applicable)

Jurisdiction(s) of registration

☐ Publicly Traded Corporation

Jurisdiction(s) of registration

☐ Incorporated by Legislation

Relevant legislation

☐ Partnership
(Complete Part A below and Part B if applicable)

Designated Representative:

Last Name | First Name | Middle Initial

Part A: Please provide a complete list of shareholders or partners (additional sheets may be added as needed).
If any of the shareholders or partners listed in Part A are corporations or partnerships, Part B must also be completed.

Please note that Publicly Traded Corporations and Corporations Incorporated by Legislation do not need to fill out this section.

1. Shareholder/Partner Name — ☐ Individual ☐ Corporation ☐ Partnership

Street Address (or P.O. Box) | City/Town

Province | Postal Code

Email Address | Phone Number

2. Shareholder/Partner Name — ☐ Individual ☐ Corporation ☐ Partnership

Street Address (or P.O. Box) | City/Town

Province | Postal Code

Email Address | Phone Number

3. _____ ☐ Individual ☐ Corporation ☐ Partnership
Shareholder/Partner Name

_____ _____
Street Address (or P.O. Box) City/Town

_____ _____ _____
Province Postal Code

_____ _____
Email Address Phone Number

4. _____ ☐ Individual ☐ Corporation ☐ Partnership
Shareholder/Partner Name

_____ _____
Street Address (or P.O. Box) City/Town

_____ _____ _____
Province Postal Code

_____ _____
Email Address Phone Number

5. _____ ☐ Individual ☐ Corporation ☐ Partnership
Shareholder/Partner Name

_____ _____
Street Address (or P.O. Box) City/Town

_____ _____ _____
Province Postal Code

_____ _____
Email Address Phone Number

Part B: Please provide a complete list of individuals with significant control over the corporation or partnership pharmacy owner (additional sheets may be added as needed).

Please note that Publicly Traded Corporations and Corporations Incorporated by Legislation do not need to fill out this section.

1. _____
Name of Individual with Significant Control

_____ _____
Street Address (or P.O. Box) City/Town

_____ _____ _____
Province Postal Code

_____ _____
Email Address Phone Number

2. _____
Name of Individual with Significant Control

_____ _____
Street Address (or P.O. Box) City/Town

_____ _____ _____
Province Postal Code

_____ _____
Email Address Phone Number

3. _____
Name of Individual with Significant Control

_____ _____
Street Address (or P.O. Box) City/Town

_____ _____ _____
Province Postal Code

_____ _____
Email Address Phone Number

4. _____
Name of Individual with Significant Control

_____ _____
Street Address (or P.O. Box) City/Town

_____ _____ _____
Province Postal Code

_____ _____
Email Address Phone Number

5. _____
Name of Individual with Significant Control

_____ _____
Street Address (or P.O. Box) City/Town

_____ _____ _____
Province Postal Code

_____ _____
Email Address Phone Number

Declaration on behalf of pharmacy owner:

☐ All information contained in this form and any related documents is accurate and complete

_____ _____
Designated Representative Signature Date Signed