ESC Provider Number(s):

EXHIBIT B – Provider Registration Declaration

SECTION A: Provider Legal Business Information

Type of Business ☐ Corporation ☐ Sole Proprietorship ☐ Partnership	Legal Business Name *(Must match Provider's governance documents (Articles of Inc., Partnership Agreement, etc.), a copy of which you are required to submit with this Agreement. Failure to provide all applicable documents may cause delays of this application and/or its denial.)*		
Legal Business Registered Office Address			
City		Province	Postal Code
Telephone	Fax	E-mail	

Owners, Officers and Directors of the Company (attach a separate sheet if necessary):

*Please list all ESC Provider numbers where an owner, officer or director has ownership in any additional pharmacies). If more than 6 owners, officers and/or directors please print and attach additional copies of this page. *If applicable*

1 Name *(first and last)*		Occupation	
Pharmacy College Registration (License) Number*	Government Photo ID No. e.g., Driver's License or Passport No. *(attach copy of ID)*		
Additional Pharmacy(ies) Owned	ESC Provider Number(s)*	Pharmacy Operating Name	
Pharmacy Address			
City		Province	Postal Code
2 Name *(first and last)*		Occupation	
Pharmacy College Registration (License) Number*	Government Photo ID No. e.g., Driver's License or Passport No. *(attach copy of ID)*		
Additional Pharmacy(ies) Owned	ESC Provider Number(s)*	Pharmacy Operating Name	
Pharmacy Address			
City		Province	Postal Code

Owners, Officers and Directors of the Company – *continued* (attach a separate sheet if necessary):

3 Name *(first and last)*		Occupation	
Pharmacy College Registration (License) Number*	Government Photo ID No. e.g., Driver's License or Passport No. *(attach copy of ID)*		
Additional Pharmacy(ies) Owned	ESC Provider Number(s)*	Pharmacy Operating Name	
Pharmacy Address			
City		Province	Postal Code

4 Name *(first and last)*		Occupation	
Pharmacy College Registration (License) Number*	Government Photo ID No. e.g., Driver's License or Passport No. *(attach copy of ID)*		
Additional Pharmacy(ies) Owned	ESC Provider Number(s)*	Pharmacy Operating Name	
Pharmacy Address			
City		Province	Postal Code

5 Name *(first and last)*		Occupation	
Pharmacy College Registration (License) Number*	Government Photo ID No. e.g., Driver's License or Passport No. *(attach copy of ID)*		
Additional Pharmacy(ies) Owned	ESC Provider Number(s)*	Pharmacy Operating Name	
Pharmacy Address			
City		Province	Postal Code

Owners, Officers and Directors of the Company – *continued* (attach a separate sheet if necessary):

6 Name *(first and last)*		Occupation	
Pharmacy College Registration (License) Number*	Government Photo ID No. e.g., Driver's License or Passport No. *(attach copy of ID)*		
Additional Pharmacy(ies) Owned	ESC Provider Number(s)*	Pharmacy Operating Name	
Pharmacy Address			
City		Province	Postal Code

Have any of the Owners, Officers, Directors or Pharmacists listed above ever applied and been denied an ESC or Eclipse Provider Number?

☐ No ☐ Yes ➔ Name(s):

Details

Have any of the Owners, Officers, Directors or Pharmacists listed above had an ESC or Eclipse Provider Number and lost billing privileges?

☐ No ☐ Yes ➔ Name(s):

Details

Do any of the Owners, Officers, Directors or Pharmacists listed above have any pending concerns at their respective regulatory body(ies)?

☐ No ☐ Yes ➔ Name(s):

Details

SECTION B: Pharmacy Information

(If registering more than one pharmacy under the same provider legal business name, make additional copies of section B)

Language ☐ English ☐ French	ESC Provider Number	Pharmacy License/Accreditation Number
Pharmacy Operating Name	Banner/Chain Name	
Pharmacy Address		
City	Province	Postal Code
Pharmacy Telephone	Pharmacy Fax	Pharmacy E-mail
Pharmacy Liability Insurance Carrier *(include certificate of liability insurance including minimum coverage amount. See Section 4.A. of the Agreement)*		Usual and Customary Professional Fee $
Pharmacy Manager Name *(first and last)*		
Pharmacy College Registration (License) Number*	Government Photo ID No. e.g., Driver's License or Passport No. *(attach copy of ID)*	

If purchasing an existing business, please indicate the following:

Existing Legal Business Name		
Existing Operating Name		
Existing Address		
City	Province	Postal Code
Existing Telephone	Existing Fax	Existing E-mail
Existing Provider Number		

Payment Information – Electronic Funds Transfer (EFT):

I instruct ESC to set up or change my direct EFT PAYMENTS. This form authorizes deposits to the bank account and does not authorize withdrawals or any other transactions with respect to the bank account. All information will be treated as PRIVATE AND CONFIDENTIAL. I will advise ESC promptly of any changes to the bank, branch or account number.

Banking Information

Attach: ☐ VOID Cheque **OR** ☐ Official Bank Letter

A copy of a pre-printed VOID cheque or Official Bank Letter is required. Corporate details must be included on either the VOID Cheque or Official Bank Letter. If the attached cheque is not pre-printed with the pharmacy's legal and/or operating name, please provide a letter signed by an officer of your bank, indicating the account number and certifying you as the account holder.

Account Holder Name		
Bank Name	Branch Name *(if applicable)*	
Branch Address		
City	Province	Postal Code
Institution No. / Bank Code	Branch / Transit No.	Account No.

Pharmacy Software Vendor Information (EDI Claims Submission):

Name of Vendor

Acknowledgment and Agreement

By signing this declaration, I am aware that the information provided may be validated and audited by ESC at any time, and that any change in the original declaration requires a re-application by the provider. Provider shall notify ESC in writing of any change or adjustment to information above twenty (20) business days in advance of such change.

Completed by:

Signature, Owner or Director of Business (no stamps)	Printed Full Name of the Owner or Director of Business
Contact Telephone Number of the Owner or Director	Date Signed *(mm/dd/yyyy)*