



Please copy this form if additional copies are required.

**REFERENCE FORM FOR PHARMACISTS APPLYING FOR  
PHARMACY LICENSURE IN THE NORTHWEST TERRITORIES -**

*MAIL COMPLETED FORM DIRECTLY TO:*

**Office of the Registrar, Professional Licensing, Department of Health & Social Services -  
Government of the NWT, Box 1320 (Centre Square Tower - 8th Floor) - Yellowknife, NWT X1A 2L9  
Telephone: (867) 920-8058 Facsimile: (867) 873-0484**

NAME OF APPLICANT (PLEASE PRINT):

*I authorize the referee to disclose to the Registrar, Northwest Territories, information relevant to licensure that would otherwise be confidential and I waive any right of disclosure of the same and agree that communication between the Registrar and the referee shall be privileged.*

SIGNATURE OF APPLICANT:

DATE:

NAME OF REFEREE (PLEASE PRINT):

APPLICANT TELEPHONE/FACSIMILE #:

**INSTRUCTIONS FOR REFEREE:** *Your personal knowledge of this applicant is important in judging suitability for licensure. Any problems or concerns that you identify below should be explained. Please use the back of this form if required.*

1. *Indicate dates where, and in what capacity, you have knowledge of the applicant. Must be within the last three years:*

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**YES      NO**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 2. <i>Are you aware of any problems regarding the applicant's physical or mental health or of any alcohol or drug problems?</i>   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. <i>Are you aware of any complaints regarding the applicant from either patients or other pharmacists?</i>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. <i>Do you know of any ethical problems the applicant has which relate to pharmacy practice?</i>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. <i>Are you aware of any aspects of the applicant's personality that may cause difficulties in professional interpersonal relationships with patients or other pharmacists?</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. <i>Is there any reason why you would not consider the applicant to have adequate knowledge, skills, and judgement required to provide pharmacy services?</i>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. <i>Have you any additional information with respect to the applicant's professional or ethical conduct that may affect their application for registration?</i>                 |                          |                          |

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SIGNATURE OF REFEREE:

DATE:

ADDRESS:

TELEPHONE #:

FACSIMILE #:

**YOU MAY FAX THIS FORM TO (867) 873-0484 HOWEVER ORIGINAL MUST BE MAILED BY  
THE REFEREE TO THE ADDRESS SHOWN ABOVE**