College of Physicians & Surgeons of Alberta

For office use only

TPP Reg # _____

Effective Date: _____

10020-100 Street Edmonton Alberta Canada T5J 4P8
P 780.423.4764 **F** 780.420.0651 www.cpsa.ab.ca

Medical Resident Triplicate Prescription Program Application Form

* Name:

_____

First Name Middle Initial(s) Last Name

Regulatory Authority License or Registration # _____

Information to be printed on pad

_____
Residency Program Name

_____
Location of Residency Program (City)

_____

_____
Telephone of Residency Program

**** Delivery Address (NO PO BOXES)**
(A signature is required at the time of delivery)

_____
Street Address

_____
Street Address

_____
City Postal Code

_____
Phone Number

Pager Number: _____ Fax Number: _____

* **Name as you would like it to appear on prescription pads.**

** **Street address required for courier delivery.**

The personal information on this form will be collected and shared for the purposes of registration in the Triplicate Prescription Program (TPP). The information may be shared with the printing and courier vendors for the purpose of producing the TPP pads. This information may also be shared with regulatory organizations as set out in the College of Physicians & Surgeons of Alberta Bylaws for the TPP. If you have any questions regarding the collection of this information, contact the TPP by email at TPPinfo@cpsa.ab.ca or by phone toll-free at 1-800-561-3899, ext # 4936 or direct at (780) 969-4932.

_____
Date

_____
Signature of Program Director

_____
Please Print Name of Program Director

_____
Date

_____
Signature of Applicant