**INR ONLINE CANADA**

**PHARMACY**

**Please complete this form for each pharmacy. All fields need to be completed. Thank you.**

|  |  |
| --- | --- |
| Pharmacy Name |  |
| Unit Number |  |
| Street Number |  |
| Street |  |
| City/Town |  |
| Province |  |
| Postal Code |  |
| Phone Number |  |
| Fax Number |  |

**PHARMACIST**

**Please complete this section of the form for each pharmacist on staff at the above pharmacy and attach a copy of their MOAT (Management of Oral Anticoagulation Therapy) certificate. Thank you.**

|  |  |
| --- | --- |
| First Name |  |
| Last Name |  |
| Email Address |  |
| Phone Number |  |

|  |  |
| --- | --- |
| First Name |  |
| Last Name |  |
| Email Address |  |
| Phone Number |  |

|  |  |
| --- | --- |
| First Name |  |
| Last Name |  |
| Email Address |  |
| Phone Number |  |