NOVA SCOTIA

Department of Health and Wellness
Pharmacy Provider Confirmation of Agreement for COVID-19 Immunization

Name of Provider _____ Provider No. _____

Address _____

Email Address _____ Effective Date _____

☐ By checking this box, it is certified the above provider accepts the terms and conditions of the Amending Agreement to the Pharmacy Service Agreement (as amended from time to time), effective February 2, 2021, between the Nova Scotia Department of Health and Wellness and the Pharmacy Association of Nova Scotia.

Signed this _____ day of _____ 20 _____

_____ _____

Authorized Signatory of Provider (Printed Name) Title

_____

Authorized Signature

PROGRAMS ADMINISTERED BY MEDAVIE BLUE CROSS
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