TPP Alberta

Medical Resident Registration Form

Using data to optimize safe patient care.

****This form is not required for re-ordering. Prescribers only need to register once.****

Registrant information:

Name: (as to appear on pad) _____
First Middle initial(s) Last

Regulatory Authority License/Registration#: _____

Pager number: _____ CPSA verified email address: _____

Preferred method of correspondence: ☐ Hard copy mail ☐ Email

Information printed on pad:

Residency Program name: _____

Location of Residency Program (city): _____

Telephone of Residency Program: _____

Delivery address:* (NO PO BOXES or OUT OF PROVINCE addresses allowed)

Street address: _____

City: _____ Postal Code: _____

Telephone: _____ Fax: _____

**A signature is required at time of delivery*

Registrant Signature: _____ Date: _____
(dd-mmm-yyyy)

Program Director's Name (Please print): _____

Program Director Signature: _____ Date: _____
(dd-mmm-yyyy)

The personal information on this form will be collected and shared for the purposes of registering in Alberta's Triplicate Prescription Program (TPP Alberta). The information may be shared with the printing and courier vendors for the purpose of producing the secure pads, OR with regulatory organizations as set out in the College of Physicians & Surgeons of Alberta Bylaws for TPP Alberta. If you have any questions regarding the collection of this information, contact the TPP Alberta at TPPinfo@cpsa.ab.ca, 780-969-4939 or toll-free at 1-800-561-3899.

Print & Sign