REFERRED CARE CLINIC

PHARMACY AGREEMENT

Referred Care Clinic - Yukon
210 Elliott Street
Box 2703 – H-2RCC, Whitehorse, YT, Y1A 2C6
Telephone: (867) 668-2552 • Fax: (867) 668-2565

{affix patient demographic label here}

I ____ understand that I am receiving medication from:

____ Referred Care Clinic – Yukon Physician **and/or**

____ Referred Care Clinic – Yukon Nurse Practitioner

I agree to the following conditions under which this medication is prescribed:

Only ____ will dispense all prescription medications for me.
NAME OF PHARMACY

I will not seek medications from any other drugstore.

____
Patient Signature

____
Physician Signature

This Pharmacy Agreement remains in effect from YYYY/MM/DD until YYYY/MM/DD.