Health PEI
One Island Health System

Santé Î.-P.-É.
Un système de santé unique

Application for Correction

Personal information on this form is collected under the *Pharmaceutical Information Act* and Regulations. This information is required in order to correct information in the Program.

Name (Last name, given name)	**Provincial Health Number** ☐☐☐☐☐☐☐☐☐☐
Mailing address Province Postal code	**Date of birth** --------/---------/--------- day / month / year **Gender** ☐ male ☐ female
e-mail address	**Identification** (Please attach copies) (You must provide two pieces of valid government issued identification, at least one of which must have a photo of you) ☐ birth certificate ☐ drivers license ☐ (other ex. Passport, Citizenship card, Immigration document, Permanent Resident Card)
Telephone Number	

Current PhIP Password (if applicable)

☐☐☐☐☐☐

Corrections/Additions requested:

Date	Name of prescriber/pharmacy	Change requested	Reason for change

☐ medication history attached ☐ additional changes attached

I am requesting the listed corrections be made to my medication history. I understand this will require the Pharmaceutical Information Program to review the changes I am requesting and I give permission to the Pharmaceutical Information Program to contact me and my prescribers, pharmacies, and pharmacists, as needed, to verify the requested corrections.

Date	Signature

Please send completed form to:
Pharmaceutical Information Program
PO Box 2000, Charlottetown, PE
C1A 7N8