

Confidentiality Undertaking

Personal information on this form is collected under the *Pharmaceutical Information Act* and Regulations. This information is required to fulfill the confidentiality requirements of the Act and regulations.

Name (Last name, given name)

Position:

Mailing address

Province

Postal code

Telephone number

I will not access or use any clinical or patient information in PhIP for any purpose other than those authorized by the *Pharmaceutical Information Act* and its regulations.

I agree at all times to treat as confidential the information in PhIP and will not participate in or permit the unauthorized release or disclosure of this information.

I agree to adhere to all legislation, policies, procedures and standards issued by PhIP related to the confidentiality, privacy and security of PhIP information.

I understand that the penalty upon conviction for any violation of the *Pharmaceutical Information Act* or regulations is a fine which may range from a minimum of \$15,000.00 to a maximum of \$50,000.00.

Date

Signature