Ontario College of Pharmacists
Putting patients first since 1871

Practice Assessment of Competence at Entry (PACE) for Pharmacy Technician Registration - Assessor Application Form (Community/Long Term Care)

Before completing this application form, please review the PACE Assessor Criteria to ensure that you are eligible to be a PACE assessor.

Please email the completed form to regprograms@ocpinfo.com. You will be notified within 8 weeks of the outcome of the application review. Thank you for your interest in being considered for this important role.

Your General Information		
A	Last Name	
	First Name	
	OCP Number	
	Business Phone Number	
	Email Address	
	Class of Registration	☐ Pharmacy Technician ☐ Pharmacist
	Years of practice as a registered pharmacy technician *OR* pharmacist providing patient care in a Canadian jurisdiction (min 2 years)	
	What experience have you had in evaluating pharmacy professionals during their registration process (e.g., OCP SPT preceptor, PEBC assessor, CCAPP college rotation preceptor)?	
	Are you currently the subject of a disciplinary or incapacity proceeding? Yes ☐ No ☐	

If you have any open cases (reports, complaints) under investigation or review or if you have any concerns listed on the Public Register that involve criminal conduct, ethical conduct, governability, sexual abuse, fitness to practice, delivery of quality healthcare or financial responsibility, you are not eligible to be a PACE assessor. If you have any questions about your eligibility to be a PACE assessor, please contact us at regprograms@ocpinfo.com.

Tell Us About You	
B	During the past year, how have you competently engaged in or with the full scope of practice of pharmacy technicians? What have you done to enhance your practice and/or the profession (e.g., professional development, projects, contribution(s) to new initiatives)?

B

Why are you interested in becoming a PACE assessor for pharmacy technician applicants?

Please describe your understanding of how PACE assessors uphold OCP's public protection mandate.

☐ I consent to the use of my practice assessment by the Registration department for the purpose of determining my initial and continued eligibility for the role of an OCP PACE Assessor.

Your Primary Practice Site Information (where PACE would occur; must match your OCP profile)

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Pharmacy Name					
Pharmacy Address (including city)					
Accreditation Number					
Type of Practice	☐ Community ☐ Long-term care				
How many hours each week do you work at this site?					
Average number of prescriptions per day					
Specialty Services Provided	**Proportion of Prescriptions**				
	<30%	**30-70%**	**>70%**		
Specialty compounding	☐	☐	☐		
Compliance packaging	☐	☐	☐		
Methadone	☐	☐	☐		
Variety and Frequency of Practice Opportunities for PACE Candidates	**Multiple times / day**	**A few times / week**	**Every 2-3 weeks**	**Rarely**	
Gather patient-related information and enter prescriptions	☐	☐	☐	☐	
Prepare/package prescriptions	☐	☐	☐	☐	
Perform final technical check of prescriptions	☐	☐	☐	☐	
Provide non-clinical information to patients (e.g., demonstrate the use of a device)	☐	☐	☐	☐	
Perform prescription transfers	☐	☐	☐	☐	
Accept verbal prescriptions	☐	☐	☐	☐	
Assist pharmacists with medication reviews (MedsChecks)	☐	☐	☐	☐	
Perform a procedure on tissue below the dermis (i.e., using a lancet-type device under pharmacist supervision)	☐	☐	☐	☐	
Collaborate with pharmacy team members and other healthcare professionals	☐	☐	☐	☐	
Contribute to the management of pharmacy inventory	☐	☐	☐	☐	
Pharmacy Staffing Please indicate the total number of staff who work at your practice site		Full Time	Part Time		
	Pharmacists	☐	☐		
	Pharmacy Technicians	☐	☐		
	Pharmacy Assistants	☐	☐		

Commitment as a PACE Assessor			
		YES	NO
D	Are you able to observe a candidate for at least 24 hours per week while practising side by side with them? **Or** Are you and a co-assessor able to split observation of a candidate over a duration of at least 24 unique hours per week while practising side by side with a candidate? If "yes", please provide the name and OCP number of your proposed co-assessor and ask them to submit a separate application. Name: _____ OCP # _____	☐ **Or** ☐	☐ **Or** ☐
	Does your manager support your participation as a PACE assessor?	☐	☐
	Does your practice site's organizational structure (e.g., staffing, resources) support your role as a PACE assessor?	☐	☐

Please provide a reference that may be contacted to comment on your practice activities and standards.

Reference Information		
E	Last Name	
	First Name	
	OCP Number	
	Contact Telephone Number	
	Email Address	

Additional Information	
F	How did you hear about PACE?
	What questions do you have about PACE?