



**YUKON
MEDICAL
COUNCIL**

Office of the Registrar of Medical Practitioners

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Whitehorse, Yukon Y1A 2C6

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Fax (867) 393-6483

TRIPLICATE PRESCRIPTION PROGRAM
APPLICATION FORM

Date: _____

Physician: _____
First Name *Initials* *Last Name*

Name of Clinic: _____

Business Address while in Yukon: _____

Clinic Phone Number _____

Name of Supervisor: _____

Physician Signature: _____

___ One temporary triplicate prescription pad (5 prescriptions) for pick up.

Unused TPP's must be returned to the Yukon Medical Council for shredding

FOR OFFICE USE ONLY

Authorized by: _____ TPP Practitioner Number: _____

Date issued: _____

Prescription Numbers issued _____ to _____