Vancouver CoastalHealth
Promoting wellness. Ensuring care.

TOBACCO & VAPOUR PRODUCTS RETAILER APPLICATION
Health Protection

This form must be completed for all new facilities and for any changes to facility information (PRINT IN BLOCK LETTERS)

Owner Legal Type: ❑ Sole Proprietor ❑ Partnership ❑ Corporation ❑ Other (define)

Legal Name of Company/Partnership/Sole Proprietor: ***(Provide a copy of certificate of incorporation)*** ***Business Licence # (if available):***

Facility Name: *(Trade Name/Doing Business As)*		**Phone:** ( )_____ **Fax:** ( )_____
Facility Site Address:	**Postal Code:** _____ **City**:_____, BC	**Website:** **E-mail:**
Director / Owner's Name: *First Name* *Last Name*		**Home Phone:** ( )_____ **Mobile Phone:** ( )_____
Operator's Name: *First Name* *Last Name*		**Home Phone:** ( )_____ **Mobile Phone:** ( )_____

Mailing Address:

Address: _____ **City:**_____ **Province:**_____ **Postal Code:** _____

Phone: ( ) _____ Fax: ( ) _____

Date of Application:_____ **Applicant's Signature:** _____

THIS BOX **MUST** BE COMPLETED FOR ALL NEW APPLICATIONS **Applicant's Name (Print):** _____

Facility Retailer Information

Facility Retailer Type

❑ Age Restricted (19+) ❑ Non-Age Restricted ❑ Vapour ❑ Liquor
❑ Tobacco ❑ Tobacco/Vapour ❑ Other ***(Please Specify)*** _____

Comments:

Tobacco Retail Authorization #			
Notice of Intent Completed	❑ Yes	❑ No	❑ N/A
Product Report Completed	❑ Yes	❑ No	❑ N/A

TVEO Name (Print):_____ **Date:** _____

TVEO Signature: _____