



## FORM FOR A REVIEW OF A SYNDIC'S DECISION



You have 30 days, upon receipt of the syndic's decision, to file a request for review.  
Following receipt of your request, the review committee will inform you of its decision within 90 days.

### ❖ APPLICANT INFORMATION

Surname :

Name :

Address :

City / Province :

Postal code :

Telephone :

E-mail :

### ❖ INFORMATION ON THE SYNDIC'S DECISION WHICH IS THE SUBJECT OF THE REQUEST FOR REVIEW

Case file number (if known) :

Name of pharmacist(s) affected by the syndic's decision (if known) :

Name of the syndic who rendered the decision :

Date of receipt of the syndic's decision :

### ❖ REASONS FOR YOUR REQUEST FOR REVIEW

Signature :

Date :

Entering your name above is equivalent to a signature.

❖ **RETURN THIS FORM DULY COMPLETED AND SIGNED :**



By mail :

Ordre des pharmaciens du Québec  
Direction des affaires juridiques  
To the attention of the secretary of the review committee  
266 rue Notre-Dame Ouest, bureau 301 Montréal (QC)  
H2Y 1T6



By e-mail :

dajso@opq.org