SCHEDULE "A"

CONFIRMATION OF PROFESSIONAL FEES

PHARMACY NAME: _____

MANITOBA HEALTH (MH) PROVIDER NO. **P**_____

PHARMACY MAILING ADDRESS: _____

PHARMACY PHONE NUMBER: _____

PHARMACY FAX NUMBER: _____

PHARMACY EMAIL ADDRESS: _____

PHARMACY MANAGER: _____

I, the Pharmacy Manager for the above-named Pharmacy, hereby confirm and certify to Manitoba Health, Seniors and Active Living that the Usual and Customary Professional Fees (as defined in the Pharmacy Agreement between The Government of Manitoba and Pharmacy Owner) the Pharmacy Owner charges its cash paying customers are as follows:

SERVICE PROVISION:	**PROFESSIONAL FEE**:
_____	$_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

NOTE TO PHARMACY MANAGER: *add additional page(s) if more space is required*

_____

Signature of Pharmacy Manager Print Name of Pharmacy Manager

Date: _____