Pharmacy Council

"We Guarantee the Highest Levels of Pharmaceutical Care"

APPLICATION FOR CPD PROGRAMME ACCREDITATION

Please refer to the CPD policy and guidelines when completing this application form

CPD PROGRAMME TITLE:………………………………………………………………

…………………………………………………………………………………………………

…………………………………………………………………………………………………

Start Date:_ _/ _ _/ _ _ **Finish Date**: _ _/ _ _/ _ _ **Duration (days):** ………………………

Name(s) of venue (s): ……………………………………………………………………………

Location/Town: ……………………………………………………………………………………

If this event is repeated and has no change to the programme or to the speakers, please add additional dates and venues below

Date(s):…………………………………………………………………………

Venue:…………………………………………………………………………..

Fee(s) to be charged to the participants: ………………………………………………………

Number of hours (excluding break times): ……………………………… **Max 6hrs per day**

Provider Organization: ……………………………………………………………………..

Name of Contact Person: ……………………………………………………………………

Contact E-mail: ………………………………………………………………………………

Contact Tel. Number (s): ……………………………………………………………………

TARGET AUDIENCE

1. **Target Audience- Professional Roles (Tick all that apply)**

- ☐ Specialists
- ☐ Trainee Pharmacist Grade
- ☐ Other………………………………………………………………………………………

[Please note that events aimed primarily at trainee pharmacist grade do not qualify for verifiable CPD credit approval]

2. **Target Audience – Practice Area**

- ☐ Hospital
- ☐ Community
- ☐ Manufacturing
- ☐ Academia & Research
- ☐ Regulation
- ☐ Ethical Representation and Promotion
- ☐ Others, specify …………………………………………………………………………

3. **Target Audience – Geographical Area**

- ☐ International
- ☐ National
- ☐ Regional

<u>CLINICAL EVENTS</u>: (Please tick all that apply)

☐ **Disease States Management**

Indicate sub- specialty……………………..…………………………………………………

☐ **Medication Therapy Management**

Indicate sub- specialty…………………..…………………………………………………..

☐ **Drug Information Services**

Indicate sub- specialty…………….………………………………………………………

☐ **Prescription Dispensing, Counseling & Communication Skills**

Indicate sub-specialty…………………………………………………………………

☐ Other…………………………………………………………………………………

NON-CLINICAL EVENTS (Please tick as appropriate)

☐ **Laws and ethics**

Indicate sub-specialty…………………………………………………………………

☐ **Industrial Pharmacy**

Indicate sub-specialty…………………………………………………………………

☐ **Pharmacy Records Management & Reporting**

Indicate sub-specialty…………………………………………………………………

☐ **Practice Research& Publication**

Indicate sub-specialty…………………………………………………………………

☐ **Management & Administration**

Indicate sub-specialty…………………………………………………………………

☐ **Sales & Marketing**

Indicate sub-specialty…………………………………………………………………

☐ **Cost & Management Accounting**

Indicate sub-specialty…………………………………………………………………

☐ **Other(s)** ……………………………………………………………………………..

Financial Declaration

Name(s) of sponsor(s) {if not Provider organization}:……………………………………

…………………………………………………………………………………………….

………………………………………………………………………………………………

Educational Details

Please list the Learning Objectives for the CPD programme below. The objectives should reflect measurable outcomes, and use action verbs such as “evaluate”, “identify”, “review”, etc.

1. ……………………………………………………………………………………
2. ……………………………………………………………………………………
3. ……………………………………………………………………………………
4. ……………………………………………………………………………………

Which teaching methods will be used? (Please tick as appropriate)

- [ ] Lectures
- [ ] Tutorials
- [ ] Discussion Group
- [ ] Practical
- [ ] Quizzes
- [ ] Demonstrations
- [ ] Workshops
- [ ] MCQ’s
- [ ] Other (Please specify)……………………………………………………………

How will the event be evaluated?...

………………………………………………………………………………………………

………………………………………………………………………………………………

Check lists

CPD providers of approved events are required:

1. To keep a record of the names of the people who attended

2. To provide attendance certificates to participants
3. To provide evaluation forms to participants
4. To have read the guidelines for Providers

Have you included in your application?

- A full programme of the meeting, including an hourly breakdown and details of the session.
- A complete list of the speakers including information about what posts they hold, where they are based and what speaking experience they have, particularly in relation to the topic to be presented. This is especially important for non-clinical topics
- All the sections in the application form and the required fee

Correspondence Details

If you wish your correspondence details to be different from those in the first section, please give the details below:

Name: …………………………………………………………………………………………

E-mail: ………………………………………………………… **Tel**:..

Address:………………………………………………………………………………………

………………………………………………………………………………………………..

Completed application form should be sent to

The Registrar

Pharmacy Council

P. O. Box 10344

Accra- North

For office use only

This CPD programme is approved for the year 20____

Accreditation fee payable :……………………………………………………………..

Received by :………………………………………………………. Date: _ _ / _ _ / _ _

CPD credits assigned for full attendance:…………………………………………….

Head of CPD Committee comments:……………………………………………………………..

..……………………………………………………………………………………………………
……………………………………………………………………………………………………..

……………………………………………………………………………………………………..

……………………………………………………………………………………………………..

Signature:……………………………………………………………… Date: _ _ / _ _ / _ _

Additional Comments:……………………………………………………………………………
………………………………………………………………………………………………………
………………………………………………………………………………………………………
………………………………………………………………………………………………………

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APPLICATION FOR CPD PROVIDER ACCREDITATION

1. CPD provider accreditation for the year beginning January_____ to December_____
2. Name of Provider: ……………………………………………………………………
3. Address:
   - I. Location: ……………………………………………………………………
   - II. Contact: ……………………………………………………………………
   - III. Email:………………………………………………………………………
   - IV. Telephone:…………………………………………………………………
4. Type of Body/Organization : (Provider Category)
   - ☐ Academic
   - ☐ Trade Union
   - ☐ Health Related Professional Body
   - ☐ Non- Health related Professional Body
   - ☐ Other (Specify)
5. Have you been accredited as a CPD Provider before? Yes ☐ No ☐
6. Anticipated number of training sessions to be held per year: ……………………………
7. Facilities to be used for CPD programme(s) e.g. *Hospital Premises, Community Pharmacies, Hotel, Rented Conference Facilities*
8. Name of Contact Person: ……………………………………………………………
9. Signature of Contact Person: …………………………Date: ………/………./………..

For office use only

Received by: …………………………………………………Date: ………/………./………..

Head of CPD Committee comments:…………………………………………………………..

…………………………………………………………………………………………………..

………………………………………………………………………………………………….

…………………………………………………………………………………………………

…………………………………………………………………………………………………

Signature:…………………………………………………..Date: ………/………./………...

Accreditation Approved: Yes ☐ No ☐ Date: ………/………./………...