



**Pharmacy Council**

Passport Size  
photograph

**PHARMACIST LICENSURE APPLICATION FORM**

**\*PHARMACISTS  
REGISTRATION NUMBER**

**(A) PERSONAL**

**TITLE**

**(Miss, Mr, Mrs, Dr, Professor)**

**\*I. SURNAME FIRST OTHER NAMES**

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**II. FORMER/MAIDEN NAME (If any)**

**\*III. NATIONALITY**

**\*IV. PERMANENT ADDRESS**

**RESIDENTIAL**

**POSTAL**

H/No.:	
Street No./Name:	
Area/Suburb:	
GPS Code:	
Town:	

**\*V. TELEPHONE NUMBER**

LANDLINE:
MOBILE:

**VI. E-MAIL ADDRESS**

**(B) EMPLOYMENT DATA**

**\*II EMPLOYER TYPE**

- GOVERNMENT/QUASI-GOVERNMENT
- PRIVATE INSTITUTION/COMPANY
- SELF-EMPLOYED

**\*III AREA OF PRACTICE**

- Hospital/MoH
- Industrial Pharmacy
- Community
- Academia/Research Representative
- Regulatory
- Medical
- Others, Please specify.....

**IV DO YOU SUPERINTEND A PHARMACY?** Yes  No

**V NAME AND LOCATION OF COMMUNITY PHARMACY**.....

**VI DO YOU OWN THIS PHARMACY?** Yes  No

**VII NAME OF HOSPITAL/ INSTITUTION CURRENTLY EMPLOYED**.....

**REGION**

**DISTRICT**

**\*(C) CONTINUING EDUCATION PROGRAMS ATTENDED**  
(ATTACH COPIES OF CERTIFICATE/CREDIT LOG BOOK)

	<b>PROGRAMME</b>	<b>DATES</b>
1		
2		
3		

SIGNATURE: ..... DATE .....

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**FOR OFFICIAL USE ONLY**

REMARKS/ RECOMMENDATIONS.....

NAME OF INSPECTOR: .....

SIGNATURE: ..... DATE .....