REGISTERED PHARMACIST PERSONAL INFORMATION

PHARMACIST REGISTRATION NUMBER

(A) PERSONAL DETAILS

TITLE (Miss, Mr., Mrs., Dr., Prof.)

I. SURNAME FIRST NAME OTHER NAMES

II. FORMER/MAIDEN NAME(if any)

III. DATE OF BIRTH IV. SEX

DAY MONTH YEAR

MALE FEMALE

V. NATIONALITY HOMETOWN REGION

VI. MARITAL STATUS

SINGLE MARRIED

VII. PERMANENT ADDRESS

RESIDENTIAL POSTAL

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

VIII. TELEPHONE NO.:
<table>
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<tr>
<th>INSTITUTION OF TRAINING</th>
<th>PROGRAM DURATION</th>
<th>QUALIFICATION OBTAINED</th>
</tr>
</thead>
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<td></td>
<td>FROM</td>
<td>TO</td>
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<td>MONTH</td>
<td>YEAR</td>
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</table>

(C) INTERNSHIP

<table>
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<tr>
<th>INSTITUTION</th>
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<td>MONTH</td>
<td>YEAR</td>
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</table>

SIGNATURE: ........................................ DATE: ........................................
THE HEALTH PROFESSIONS REGULATORY BODIES ACT, 2013 (ACT 857)

SECTIONS 82-84

APPLICATION FOR REGISTRATION AS A PHARMACIST

THE REGISTRAR
PHARMACY COUNCIL
P.O.BOX AN 10344 ACCRA-NORTH.

I ……………………………………...…………………………………….......
(SURNAME)

…………………………………….......
(FIRST NAME)

…………………………………….......
(OTHERS)

of ……………………………………………………………………………………………………………………………………………
(PERMANENT POSTAL ADDRESS)

Hereby make application for registration as a Pharmacist. My qualification(s) are

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

I enclose registration fee of GH₵………………………………………………………………

Signature: …….………………………………

Date: …………………………………………...

Pharmacy Council Receipt No.: ………………………………….

Amount Paid: GH₵ ………………………………..

Pharmacist Registration No.: ……………………………..

Date: …………………………………………………

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