PHARMACY TECHNICIAN LICENSURE APPLICATION FORM

*PIN NUMBER

(A) PERSONAL DATA

TITLE (Miss, Mr, Mrs)

*I. SURNAME FIRST OTHER NAMES

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

*IV. DATE OF BIRTH (DD/MM/YYYY)

*V. PERMANENT ADDRESS

RESIDENTIAL POSTAL

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

*VI. TELEPHONE NUMBER VII. EMAIL ADDRESS

MOBILE:
(B) EMPLOYMENT DATA

* I EMPLOYER TYPE

☐ GOVERNMENT/QUASI-GOVERNMENT
☐ PRIVATE INSTITUTION/COMPANY

* II AREA OF PRACTICE

☐ Hospital/MoH  ☐ Industrial Pharmacy  ☐ Community
☐ Academia/Research  ☐ Pharmaceutical Marketing

Please State workplace details......................................................................................................

REGION

DISTRICT

*(C) CONTINUING EDUCATION PROGRAMS ATTENDED

(ATTACH COPIES OF CERTIFICATE)

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*(D) ATTACH EVIDENCE OF MEMBERSHIP OF A RECOGNISED NATIONAL PROFESSIONAL ASSOCIATION

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

FOR OFFICIAL USE ONLY

REMARKS/RECOMMENDATIONS...........................................................................................................
..........................................................................................................................................................
NAME OF INSPECTOR: ..........................................................................................................................
SIGNATURE: .......................................................... DATE .............................................