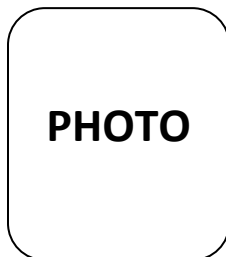


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**APPLICATION FOR PERMANENT REGISTRATION AS A PHARMACIST**



YEAR \_\_\_\_\_

**Personal Information:**

Surname: \_\_\_\_\_

First Name: \_\_\_\_\_ Other Name: \_\_\_\_\_

Gender: Male ☐ Female ☐

Date of Birth: \_\_\_\_\_ Nationality: \_\_\_\_\_

National ID No: \_\_\_\_\_ Issuing Date: \_\_\_\_\_

Physical Address: \_\_\_\_\_

State: \_\_\_\_\_ County: \_\_\_\_\_ Town/City: \_\_\_\_\_

Phone No: \_\_\_\_\_ Email: \_\_\_\_\_

**Academic Qualification:**

Degree/ Certificate Held: \_\_\_\_\_

Date Qualified: \_\_\_\_\_ No. of Years Training undertaken: \_\_\_\_\_

School/College: \_\_\_\_\_

University/ Institute: \_\_\_\_\_

Contact details: \_\_\_\_\_

Website: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Name of Internship Training Facility: \_\_\_\_\_

Tel No: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Description	Training Facility	Tel No	E-mail Address	Period of Internship
1. Hospital Pharmacy				From: To:
2. Community Pharmacy				From: To:
3. Supply Chain Management				From: To:
4. Industrial Pharmacy (optional)				From: To:
5. Regulatory Authority				From: To:

Particulars and testimonials covering the period(s) of experience. Please list and provide/attach all supporting evidence. Only certified true copies must be provided/attached:

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**Name of the Employer:** \_\_\_\_\_

Address: \_\_\_\_\_ Town: \_\_\_\_\_

County: \_\_\_\_\_ State: \_\_\_\_\_

Tel No: \_\_\_\_\_ E-mail: \_\_\_\_\_

### Requirements

- (i) Copy of National ID/Passport
- (ii) Four (4) colored passport sized photo with Name and Id number indicated at the back.

- (iii) *Certified copies of professional, academic certificates and Academic Transcripts.*
- (iv) *All Academic/Professional and transcript certificates have to be authenticated from the relevant specialized authority.*
- (v) *Any certificate in a language other than English will have to be accompanied with a translated version.*
- (vi) *Evidence of completion of the internship.*
- (vii) *Evidence of completing Pharmacist training in an accredited University (Locally or regionally) The institution must appear in the list submitted by deans of Accredited National Pharmacy Schools or other relevant and accredited institutions. If regional institution must have reciprocal recognition.*
- (viii) *Evidence of registration from partner States' Medical Boards and Councils (for those with foreign qualifications and internship training).*
- (ix) *All credentials from foreign countries must be verified by any of the council's recognized international verification agency (EPIC, Dataflow, etc.).*
- (x) *Application & License fees (see the attached fees structure)*
- (xi) *All payments are **non-refundable** and should be made at the given **Bank details**. The original banking slip must be submitted together with the form.*

**(COOPERATIVE BANK OF SOUTH SUDAN, JUBA BRANCH, AC NAME:  
SOUTH SUDAN GENERAL MEDICAL COUNCIL, AC#: 01126004358500)**

**Declaration:**

*I hereby certify that the above information is correct to the best of my knowledge and that I have met the above requirements.*

Signature of applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**For Official Use:**

**Verified by:**

Name: \_\_\_\_\_ Designation: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Recommended by:**

Name: \_\_\_\_\_ Designation: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Approved** ☐

**Not Approved** ☐

Name: \_\_\_\_\_ Designation: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_