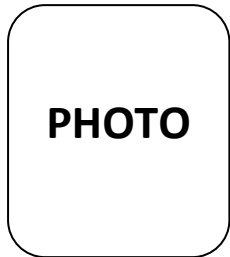

APPLICATION FOR PERMANENT REGISTRATION AS A PHARMACIST



YEAR _____

1. Personal Information:

1.1. Surname: _____

1.2. First Name: _____ Other Names: _____

1.3. Gender: Male Female

1.4. Date of Birth: _____ Nationality: _____

1.5. National ID No: _____ Issuing Date: _____

1.6. Physical Address: _____

1.7. State of Origin: _____ County: _____ Town: _____

1.8. Phone No: _____ Email: _____

2. Academic Qualification:

2.1. Degree/ Certificate Held: _____

2.2. Date Qualified: _____ No. of Years Training undertaken: _____

2.3. School/College: _____

2.4. University/ Institute: _____

2.5. Contact details: _____

2.6. Website: _____

2.7. Contact Phone: _____ Email: _____

3. Name of Internship Training Facility: _____

3.1. Tel No: _____ E-mail Address: _____

3.2. Internship Training Details:

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:

3.3. 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:

4. Name of the Employer: _____

Address: _____ Town: _____

County: _____ State: _____

Tel No: _____ E-mail: _____

5. Requirements

- (i) Copy of National ID/Passport
- (ii) Two (2) colored passport sized photo.
- (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).
- (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 MEDICCAL COUNCIL, AC#: 01126004358500)**

6. 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: _____