The Council of The Pharmaceutical Society of Uganda

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Our Ref:
Your Ref:
Date:

Application No: _____

PHARMACIST'S CERTIFICATE OF PRACTICE APPLICATION FORM FOR THE YEAR 2015

(In accordance with The Pharmacy and Drugs Act CAP 280 Sections 9, 11, 19and 21)

Please duly complete this form. Incomplete applications with insufficient information will not be considered.

1. Pharmacist's name _____
2. Registration number_____
3. Year of registration_____
4. Name of Company/Organization/Pharmacy where practice is intended to be carried out
   _____
5. Nature of employment (Tick as appropriate) : Fulltime ☐ Part-time ☐
6. Physical address of the premises where the practice is intended to be carried out
   _____
   _____
7. The Company/Pharmacy/Organization offers services of :

Category	Tick as applicable	Category	Tick as applicable
Retail		Regulatory	
Wholesale		NGO	
Wholesale and Retail		Private Hospital	
Small-scale manufacturing		Public Hospital	
Large scale manufacturing		Research/Academia	
Others (Describe)			
No. of Employees in the Organization			

8. Category of Medicines being sold/distributed/Manufactured from the Facility (If applicable)

Human	
Veterinary	
Others(describe)	

9. Category of Pharmacy /Organization(Tick as appropriate) : New ☐ Existing,☐ How long _____
10. How long has the Pharmacist been working with the organization(years)_____
    If changing Pharmacists, name of outgoing/previous Pharmacist_____
11. Clearly state the working hours of the outlet /Organization
    _____

12. Time of attendance at the Premises /Organization (Minimum 20 hours a week spread out over a minimum of 3 days)

Day of the week	Time(s) of attendance	Day of the Week	Time(s) of Attendance
Monday		Friday	
Tuesday		Saturday	
Wednesday		Sunday	
Thursday		-----	

13. Details of the Pharmacy auxiliary staff (PAS) /Technical staff/Medical representative/Key personnel. (Additional attachments may be provided. For manufacturing facilities the names of the production manager, QC/QA manager alongside the production officers/analysts should be provided. For Medical representatives a list of products that they promote should be attached)

No.	Name	Qualification	Position/ Role	Years at the organization	Trained by PSU(Yes/ No/Not applicable)	Phone	DIN(PSU Database Identification No.)

14. For each auxiliary/technical staff/key personnel indicate the days and hours that they shall be working

No.	Name	Days of the week	Hours per week

For the Pharmacist

15. Pharmacy qualifications , institutions attended and other qualifications

_____

_____

16. Continous Professional development attained during the course of the year (Certificates should be attached with a minimum of at least one PSU CPD attendance as applicable)

No.	Date of training	Hours of training	Training institution	Theme of training

17. Are you satisfied with the premises, documentation, professional service delivery and personnel performance in the facility in which you are practicing in (Yes/No)? _____ If no what changes do you propose?

_____

_____

Indicate Size of the floor area of the premises (m^2) _____

18. Do you have an employment contract with your employer, detailing Pharmacists'/employees' roles, Compliance to PSU,NDA regulatory instruments, remuneration, termination, working hours, notice period, mediation, conflict resolution, effective date(Yes/No)_____,

NB. A clause indicating that the employer shall not allow the Pharmacist to work under conditions that compromise their professional judgment shall be included in their employment contract.

19. Do you currently hold or intend to hold a certificate of practice for a different facility (Yes/No)____.If Yes,where_____

20. Are You in full time employment elsewhere (Yes/No)_____? If yes give details of the organization & your position_____

21. Chronology of areas worked in over the last 3 years

Name of Pharmacy /Organization	Years of Practice

22. Attachments/Submissions (Tick (√) if attached and (X) if not attached or NA if not applicable.

No.	Document	Attached (√ or X or NA)	Remark if not attached
1.	Commitment letter of the Supervising Pharmacist endorsed by the Managing Director		
2.	Commitment letter of all the Pharmacy auxiliary staff/Medical representatives/Technical staff endorsed by the Managing Director		
3.	Commitment letters accompanied by one Passport size photo of the PAS/Medical Representative or Key personnel.		
4.	Certified Registration certificates and academic transcripts of the Pharmacy auxiliary staff (PAS) /Medical Representatives/Key personnel in the industry.		
5.	Workplace Identity card copies of all the PAS attached		
6.	PSU Pharmacy auxiliary staff training certificate or written commitment to attend future training.		
7.	Dimension &Area layout of the premises of practice (Pharmacies) clearly stipulating the demarcations for storage and dispensing and prescription area if not previously submitted or if changed.		
8.	A copy of CPD certificate issued by PSU.		
9.	Duly filled changeover forms in case of Pharmacies that are changing Pharmacists.		
10.	Filled self-inspection checklists submitted to PSU		
11.	Receipts for payment of subscription, development and Pharmacy fees as applicable		

I hereby certify that the above information is true and correct and do commit myself to securing the highest practicable Standards in the Practice of Pharmacy and compliance to the Pharmacist's oath and code of conduct at all times.

Name of the Supervising/Practicing Pharmacist: _____

Date & Signature: _____

Contact Information (Mandatory)

Item	Pharmacist	Place of Work
Telephone 1		
Telephone 2		
Email address		
Postal Address		

Name of Directors/Partners of the Firm (One of the directors/partners MUST be a Pharmacist- applicable to Pharmacies and Pharmaceutical manufacturing facilities)

No.	Name of Partner/Director	Qualification

Signature of Managing Director/Organization head_____

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1. **Information verified : Yes ☐ No ☐**
2. **Form duly filled : Yes ☐ No ☐**
3. **All attachments provided : Yes ☐ No ☐**
4. **Application approved : Yes ☐ No ☐**

If not approved reason

_____

_____

_____

Signed & date:

_____

Secretary, Council of the Pharmaceutical society of Uganda