PHARMACISTS COUNCIL OF ZIMBABWE

APPLICATION FOR ACCREDITATION AS A CONTINUOUS PROFESSIONAL DEVELOPMENT PROVIDER

(to be completed and submitted with the applicable fees)

I/We, the undersigned do hereby apply for accreditation as provider(s) of continuous professional education programmes to pharmacists/ pharmacy technicians/ dispensing opticians/ optometrists/ hearing aid specialists. I/We are professionals of good standing and do undertake to provide quality training and continuous professional development programmes to other professionals. I/We are knowledgeable about the law relating to the practice of pharmacy/ optometry/ hearing aid specialization in Zimbabwe

1 NAME OF APPLICANT:

NAME: DR/MR/MRS ……………………………………………………………………………………
FIRST SURNAME

REGISTRATION CERTIFICATE NO: ………………………………………………………………

PRACTISING CERTIFICATE NO: ………………………… EXPIRY DATE: …………………

QUALIFICATIONS: ……………………………………………………………………………………

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2. WORK EXPERIENCE (Number of Years- for individuals)

HOSPITAL ……………………… INDUSTRY …………………………………

RETAIL …………………………… ACADEMIA ……………………………….

3. COMMUNICATION DETAILS

ADDRESS……………………………………………………………………………………………

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E-MAIL ADDRESS ……………………………………………………………………………………

TELEPHONE NUMBER: ……………………………………………………………………………

CELL NUMBER…………………………………………………………………………………………

3. MEMBERSHIP OF PROFESSIONAL ASSOCIATIONS (individuals only)

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4. TYPE OF COURSE(S)/ACTIVITYTO BE OFFERED

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5. TARGET GROUP

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6. TOPIC(S) TO BE COVERED

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7. LENGTH OF COURSE(S)

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8. TRAINING VENUE(S)

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9. ANY OTHER INFORMATION THAT MAY BE IMPORTANT FOR THIS APPLICATION

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SIGNED………………………………………… DATE…………………………….

<u>FOR OFFICIAL USE ONLY</u>

Approved/ Not approved

Conditions………………………………………………………………….

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Other Comments……………………………………………………..

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Name…………………………………. Designation……………………..

Date…………………………