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 2016

(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/year_____
3. Name of Company/Organization/Pharmacy where practice is intended to be carried out
   _____
4. Nature of employment (Tick as appropriate) : Fulltime ☐ Part-time ☐
5. Physical address of the premises where the practice is intended to be carried out
   _____
   _____
6. 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		Medical representation	
No. of Employees in the Organization			

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

Human	
Veterinary	
Others(describe)	

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

11. 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		-----	

12. 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.)

13. 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

14. Pharmacy qualifications , institutions attended and other qualifications

_____

_____

15. 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

16. 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) _____

17. 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.

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

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

20. 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 & passport photo of all the Pharmacy auxiliary staff/Medical representatives/Technical staff endorsed by the Managing Director		
3.	Certified Registration certificates and academic transcripts of the Pharmacy auxiliary staff (applicable if no DIN no. available		
4.	PSU Pharmacy auxiliary staff training certificate or written commitment to attend future training.		
5.	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.		

6.	A copy of CPD certificate issued by PSU.		
7.	Duly filled changeover forms in case of Pharmacies that are changing Pharmacists.		
8.	Receipts for payment of subscription, Pharmacy fees and other relevant fees as applicable		

I hereby certify that the information indicated and attached 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, code of conduct and supervisory guidelines at all times.

Name of the Supervising/Practicing Pharmacist: _____

Date & Signature_____

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	Contact

I hereby commit to providing the needed administrative support to the Pharmacist and technical staff to secure the highest practicable standards in the practice of Pharmacy and compliance to regulatory and statutory obligations at all times.

Signature of Managing Director/Organization head_____

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1. **Information verified : Yes ☐ No ☐**
2. **Application approved : Yes ☐ No ☐**

If not approved reason

_____

_____

Signed & date:

_____

Secretary, Council of the Pharmaceutical society of Uganda