The Council of The Pharmaceutical Society of Uganda

Our Ref:
Your Ref:
Date:

P.O BOX, 3774
Kampala, Uganda
Telephone: 0414348796, 0392174280
Email: psupc@psu.or.ug
Website: www.psu.or.ug

APPLICATION FORM FOR A CERTIFICATE OF PRACTICE 2020
(In accordance with The Pharmacy and Drugs Act CAP 280 Sections 9, 11, 19 and 21)

(Fill all items on this form and append attachments wherever necessary.)

Print or use capital letters.

Application No: _____

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

1. Pharmacist's name _____
2. Registration number/year of registration_____
3. Physical address of the Pharmacist
   _____
   _____

4. Which pharmacy practice have you been practicing during the previous year:

Category	Tick as applicable	Category	Tick as applicable
Retail Pharmacy		Regulatory	
Wholesale pharmacy		NGO	
Wholesale and Retail pharmacy setting		Private Hospital	
Manufacturing		Public Hospital	
Marketing/ sales		Research/Academia	
Procurement and supply chain management		Medical representation	
Pharmaceutical Consultancy			
Others (please specify)			

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5. Which pharmacy practice field do you intend to practice during the year :

Category	Tick as applicable	Category	Tick as applicable
Retail Pharmacy		Regulatory	
Wholesale pharmacy		NGO	
Wholesale and Retail pharmacy setting		Private Hospital	
Manufacturing		Public Hospital	
Marketing/ sales		Research/Academia	
Procurement and supply chain management		Medical representation	
Pharmaceutical Consultancy			
Others (please specify)			

6. Which Category of Medicines do you intend to supply/ dispense/manufacture during the course of the year (If applicable)

Human	
Veterinary	
Herbal medicines	
Others(describe)	

7. Clearly state the Practice Setting in which you are currently practicing (or intend to practice) together with the time of attendance to duty at each Practice Setting.

Sr. No.	Name, Physical Address and contact of the Practice Setting.	Time of attendance

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8. State the number of hours of Continuous Professional development attained during the course of the year (Minimum hours prescribed by the Council; Attach copy of your CPD Diary/ record)

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

_____

_____

_____

I hereby certify that the information indicated 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 for Pharmacists in Uganda at all times.

Name of the Supervising/Practicing Pharmacist: -_____

Date & Signature_____

Phone_____ Email_____

For Official Use only

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

If not approved provide reason below

_____

_____

_____

Secretary, Council of the Pharmaceutical Society of Uganda