

PHARMACY BOARD OF PAPUA NEW GUINEA



APPLICATION FORM FOR RETENTION OF NAME IN THE REGISTER

(PHARMACIST)

To: The Chairman
Pharmacy Board of Papua New Guinea
PO BOX 807
WAIGANI
PAPUA NEW GUINEA

Phone: 675 301 3866
Fax: 675 323 1631

1. I _____
(Surname) (Other Names in Full)

Registration number _____

require my name to be retained in the register and hereby apply for a Practicing License as a Pharmacist.

2. (a) Qualification _____
(Any new qualification?)

(b) I enclose herewith the amount of K50 – Pharmacist Annual renewal fee

(Note: Fees must be payable to Pharmacy Board of PNG, vote 140/08 at the Provincial Finance and Treasury Cashier Office)

3. I forward the following particulars:

Address:- (i) Residential: _____

Postal: _____
Province: _____
Telephone: _____

(ii) Office Location: _____
Name: _____
Address: _____
Telephone: _____ Fax: _____

(iii) Are you in Public/Private Practice? _____

NOTE: Registered Pharmacist should send immediate notice of any change of registered particulars to the Chairman Pharmacy Board of Papua New Guinea, PO Box 807, Waigani, Papua New Guinea

4. I hereby certify that the particulars submitted herein are true.

Declared at _____
This ____ day of _____ 200____ (Signature of Applicant)

Before me _____
(Commissioner of Oath/Justice of Peace/Notary Public)

OFFICE USE ONLY:

(a) Is the application approved or rejected? _____
(b) If rejected, state reason (s) _____
(c) Signed by _____ Date: _____