

APPLICATION FOR A EUROPEAN CERTIFICATE OF CURRENT PROFESSIONAL STATUS

SECTION 1 IMPORTANT INFORMATION

- Payment of the fee of £50 must be submitted with this application by cheque or payment by credit/debit card in Society offices¹.
- This application fee is non refundable
- European Certificates of Current Professional Status take up to 5 working days to produce on receipt of a complete application.

SECTION 2 PERSONAL DETAILS

REGISTRATION NUMBER	<input type="text"/>
TITLE	<input type="text"/>
SURNAME	<input type="text"/>
FORENAMES (AS ON BIRTH CERTIFICATE)	<input type="text"/>
ADDRESS LINE 1	<input type="text"/>
TOWN/CITY	<input type="text"/>
COUNTY	<input type="text"/>
POST CODE	<input type="text"/>
COUNTRY	<input type="text"/>
DATE OF BIRTH	<input type="text"/>
HOME TEL NO.	<input type="text"/>
MOBILE	<input type="text"/>
EMAIL ADDRESS	<input type="text"/>
NATIONALITY	<input type="text"/>

SECTION 3 DEGREE DETAILS

QUALIFICATION	<input type="text"/>
UNIVERSITY WHERE GAINED	<input type="text"/>
YEAR GAINED	<input type="text"/>

¹ Payee must be present in the office to use the chip & pin facility. Please note there will be a 2.4% surcharge for all credit card transactions.

SECTION 4 PRE-REGISTRATION TRAINING DETAILS (IN NORTHERN IRELAND)

PLACEMENT NO.1

DATE TRAINING BEGAN

Day Month Year

DATE TRAINING COMPLETED

Day Month Year

NAME OF PRE-REGISTRATION TRAINING PLACEMENT

ADDRESS OF PLACEMENT

PLACEMENT NO. 2 (if applicable)

DATE TRAINING BEGAN

Day Month Year

DATE TRAINING COMPLETED

Day Month Year

NAME OF PRE-REGISTRATION TRAINING PLACEMENT

ADDRESS OF PLACEMENT

SECTION 5 OVERSEAS BOARD

YOUR APPLICATION MAY REJECTED IF ANY INFORMATION IN THIS SECTION IS MISSING

NAME OF OVERSEAS BOARD/COUNCIL TO WHICH THE CERTIFICATE IS TO BE SENT

ADDRESS OF OVERSEAS BOARD/COUNCIL TO WHICH THE CERTIFICATE IS TO BE SENT

SECTION 6 FITNESS TO PRACTISE

ARE YOU CURRENTLY REGISTERED WITH ANY OTHER REGULATORY BODY?

YES NO

HAVE YOU PREVIOUSLY BEEN REGISTERED WITH ANY REGULATORY BODY?

YES NO

If you have answered 'yes' to either question above please provide details.

NAME OF BODY

ADDRESS OF BODY

COUNTRY

1. HAVE YOU EVER RECEIVED A CAUTION OR BEEN CONVICTED OF AN OFFENCE WITHIN THE UK OR ELSEWHERE OTHER THAN A MOTORING OFFENCE NOT RESULTING IN DISQUALIFICATION YES NO
- (The position of Pharmacist is exempt from the provisions of the Rehabilitation of Offenders (Northern Ireland) Order 1978. Therefore you must declare all convictions including those that would be considered "spent" under this legislation.)
2. ARE YOU SUBJECT OF ONGOING OR PENDING CRIMINAL PROCEEDINGS IN THE UK OR ELSEWHERE OTHER THAN A MOTORING OFFENCE NOT RESULTING IN DISQUALIFICATION? YES NO
3. ARE YOU SUBJECT TO ANY FINDINGS OR DETERMINATIONS BY A LICENSING OR REGULATORY BODY IN THE UK OR ELSEWHERE? YES NO
4. ARE YOU SUBJECT TO SEX OFFENDER NOTIFICATION REQUIREMENTS? YES NO
5. ARE YOU LISTED ON THE DISQUALIFICATION FROM WORKING WITH CHILDREN OR VULNERABLE ADULTS LIST IN NORTHERN IRELAND, RELEVANT SCOTTISH LISTS OR OTHER LISTS HELD BY THE DEPARTMENT OF CHILDREN, SCHOOLS AND FAMILIES AND DEPARTMENT OF HEALTH IN ENGLAND AND WALES? YES NO

If your answer is YES to any of the above, please provide details of convictions/proceedings and any evidence that you consider would help support your claim of good character for consideration by the Registrar using page 4 of this form. Please note any convictions declared will be verified with the Criminal Records Bureau or equivalent.

CHARACTER DECLARATION BY THE PHARMACIST:

I declare that the information provided above (PARTS 1-5) is true.

YES NO

I am a suitable person to practise as a pharmaceutical chemist. _

YES NO

HEALTH DECLARATION

Principle 6.6 of the Code of Ethics 2009 states that you must:

"Practise only if you are competent and fit to do so. Promptly inform the Society, your employer and other relevant authorities of any circumstances that may call into question your fitness to practise or bring the pharmacy profession into disrepute, including ill-health (which includes chemical dependence), impairing ability to practise."

Are there any issues in relation to your mental or physical health that may impair your fitness to practise that you have not previously advised the Registrar?

PLEASE TICK APPROPRIATE BOX

YES

NO

If you are concerned that a physical or mental health problem may impair your ability to practise, you must seek to clarify this with your physician or consultant and make a health declaration in writing to the Registrar. Any information supplied must be marked 'Confidential' and for the attention of the Registrar only. Please note you may be asked to undertake an occupational health assessment commissioned by the Society..

DECLARATION BY APPLICANT

I DECLARE THAT:

ALL OF THE INFORMATION I GIVE IN THIS FORM AND IN ANY SUPPORTING DOCUMENTS IS ACCURATE

I WILL COMPLY WITH THE CODE OF ETHICS PUBLISHED BY THE SOCIETY'S COUNCIL

I UNDERSTAND AND I AM ABLE TO UNDERTAKE THE RESPONSIBILITIES OF A REGISTERED PHARMACIST, WHICH I ACKNOWLEDGE MAY INCLUDE TAKING SOLE CHARGE OF A COMMUNITY OR HOSPITAL PHARMACY AND THE PROVISION OF ADVICE IN RELATION TO THE SCIENCE OF MEDICINES OR THE PRACTISE OF PHARMACY OR HEALTHCARE.

I HAVE A DUTY TO NOTIFY THE REGISTRAR OF ANY CHANGES TO MY NAME, HOME ADDRESS OR OTHER CONTACT DETAILS

I HAVE A DUTY TO NOTIFY THE REGISTRAR OF ANY FITNESS TO PRACTISE MATTERS PRIOR TO REGISTRATION, AND WITHIN 7 DAYS OF ANY OCCURRENCE AFTER REGISTRATION.

IF I AM FOUND TO HAVE GIVEN FALSE OR MISLEADING INFORMATION IN CONNECTION WITH THIS APPLICATION, THIS MAY BE TREATED AS MISCONDUCT FOR THE PURPOSES OF THE PHARMACY (NI) ORDER 1976, WHICH MAY RESULT IN MY REMOVAL FROM THE REGISTER.

IN LINE WITH THE DATA PROTECTION ACT 1998, THE SOCIETY MAY SHARE SOME OF THE INFORMATION PROVIDED IN THIS FORM WITH OTHER AGENCIES FOR REGULATORY PURPOSES E.G. INSPECTORATE OF THE DEP. OF HEALTH & SOCIAL SERVICES AND PUBLIC SAFETY.

SIGNED

DATE

Additional information to supplement application [if applicable]